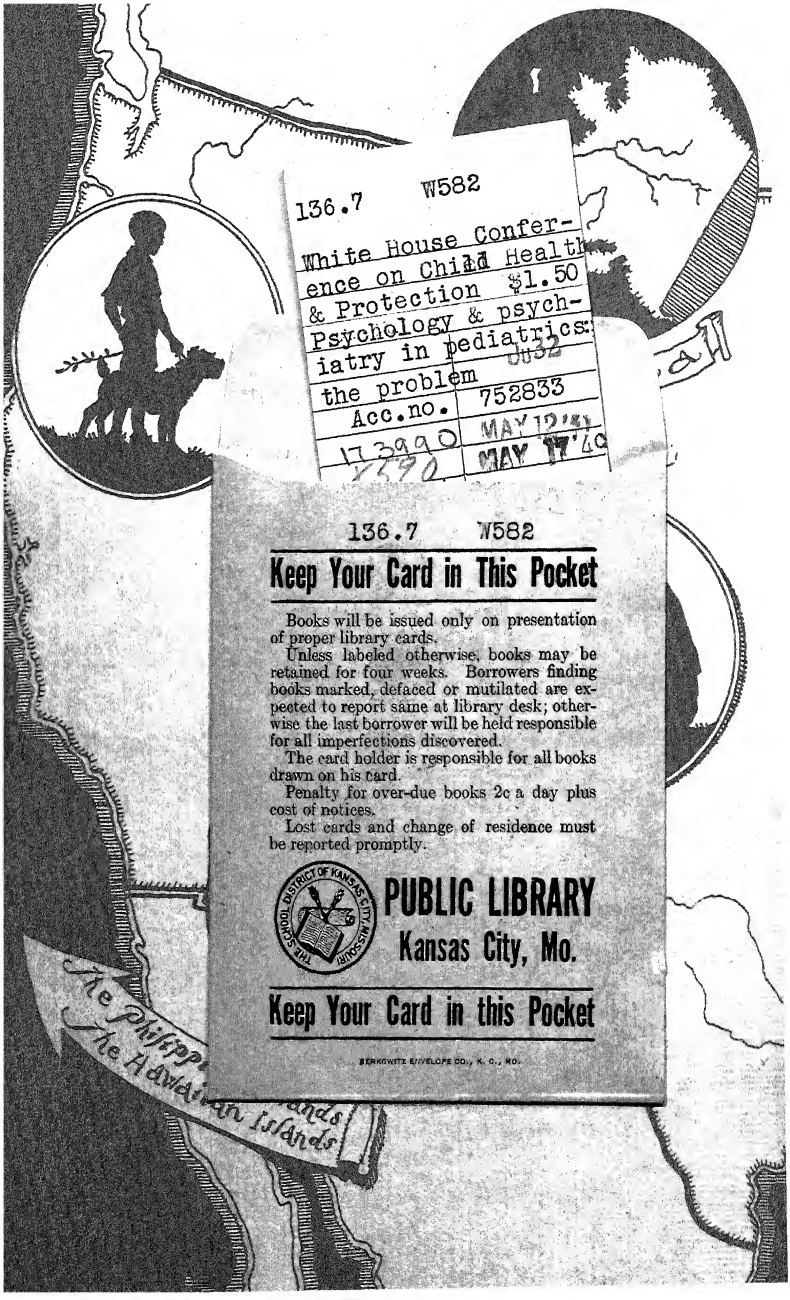

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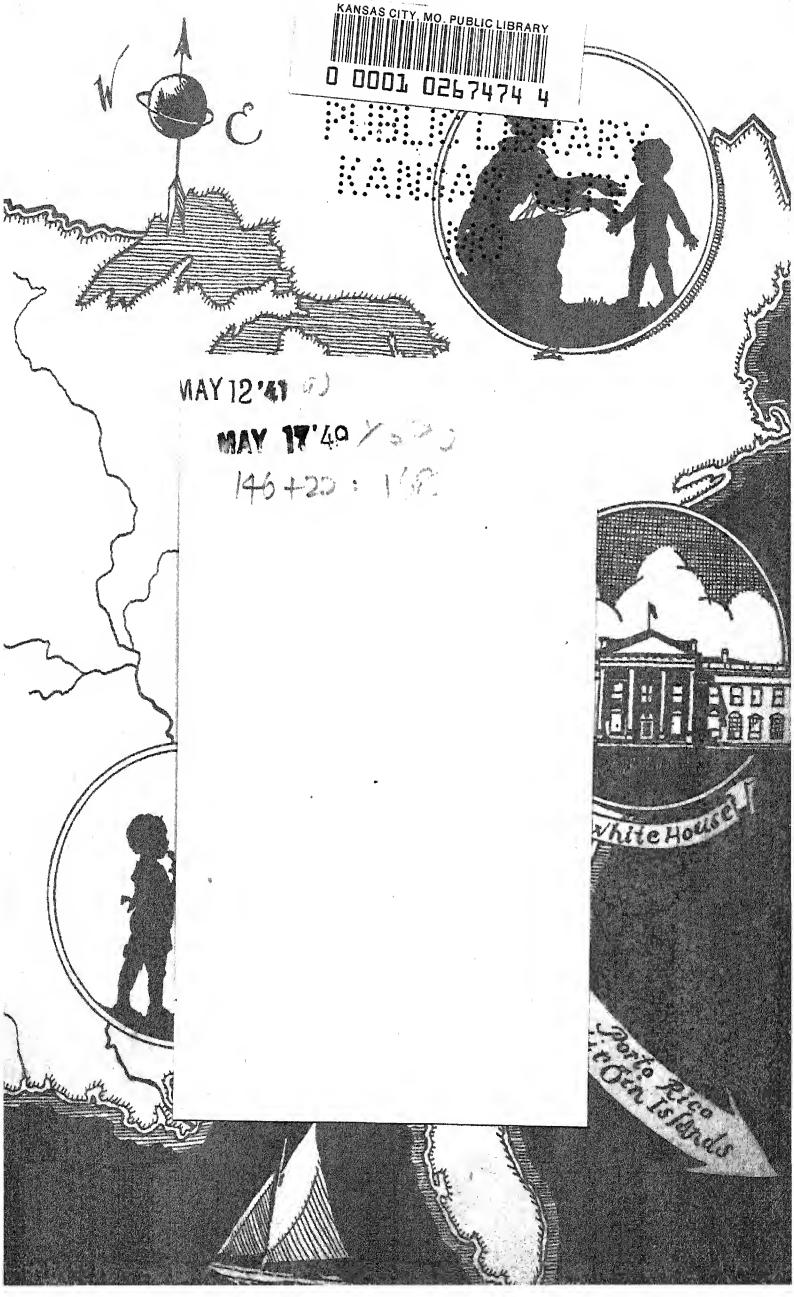

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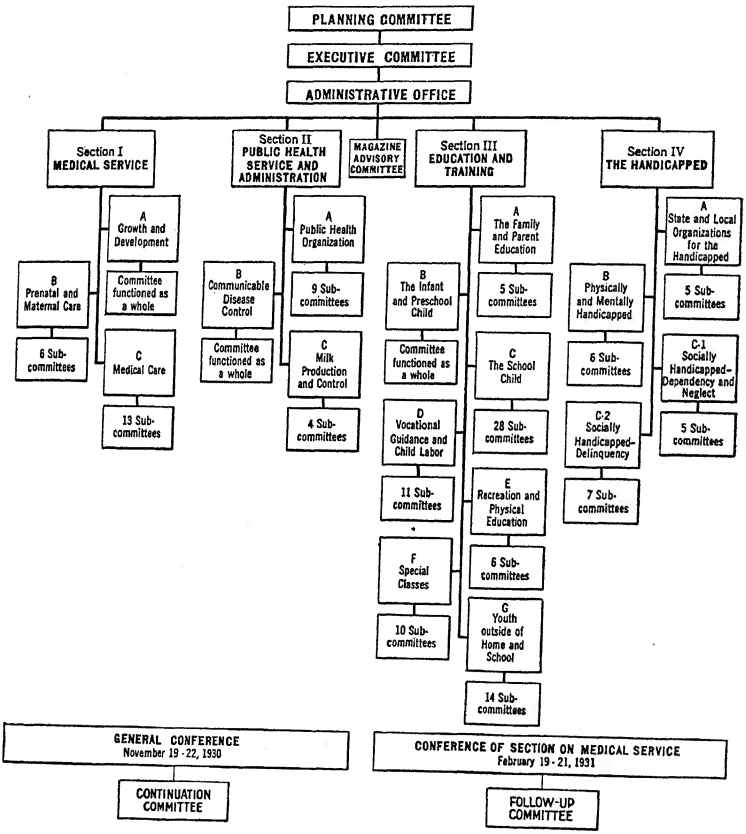

Section I—MEDICAL SERVICE

Samuel McC. Hamill, M.D., *Chairman*

Committee on

MEDICAL CARE FOR CHILDREN

Philip Van Ingen, M.D., *Chairman*

PSYCHOLOGY AND PSYCHIATRY IN PEDIATRICS: THE PROBLEM

II For every child understanding and the guarding of his personality as his most precious right

From THE CHILDREN'S CHARTER

PSYCHOLOGY *and* PSYCHIATRY *in* PEDIATRICS: THE PROBLEM

REPORT OF THE SUBCOMMITTEE
ON PSYCHOLOGY AND PSYCHIATRY
BRONSON CROTHERS, M.D., *Chairman*

WHITE HOUSE CONFERENCE ON
CHILD HEALTH AND PROTECTION

THE CENTURY CO.
NEW YORK LONDON

PRINTED IN U. S. A.

Dedicated to

THE CHILDREN OF AMERICA

WHOSE FACES ARE TURNED TOWARD THE LIGHT OF A NEW DAY AND WHO MUST BE PREPARED TO MEET A GREAT ADVENTURE

SECTION I

MEDICAL SERVICE

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PSYCHOLOGY AND PSYCHIATRY IN PEDIATRICS: THE PROBLEM

PSYCHOLOGY AND PSYCHIATRY IN PEDIATRICS: THE PROBLEM

INTRODUCTION

THIS Subcommittee realizes that no useful purpose will be served by a general discussion of psychiatry and psychology. It has confined its investigation to those aspects of these subjects which are of direct interest to physicians in charge of the medical care of children.

It has been clear to all of us from the start that perilous and fascinating fields of study are open to anyone who expresses interest in psychiatry and psychology. Eager guides are ready to show him that the prevention of insanity, the control of crime and the conduct of education are of such great importance and complexity that the troubles of the individual doctor and the individual child in distress are simple in comparison. For the purposes of this report, however, we are confining our efforts to the more restricted field. It is evident that unless we can avoid interminable discussion as to definitions we are helpless in presenting a point of view. It is also clear that we should be rash indeed to insist that these definitions are accurate enough to stand under all circumstances.

Psychology is a science dealing with mental processes and human behavior. In so far as children are concerned, most of the teachers and leaders are interested in research and in determining the underlying trends in groups rather than in the individual peculiarities which lead to distress. The major efforts of many psychologists who are studying children are devoted to the study of the aptitudes and disabilities which affect educational procedures. On the whole,

the authority of psychologists is greatest in decisions involving the intellectual capacity of the children studied and in problems relating to learning and the acquisition of both intellectual and motor skills. However, the research and scientific publications of psychologists cover almost every aspect of behavior and adjustment.

Psychiatrists have, as a group, a different fundamental training and their efforts are directed toward the understanding of individuals in distress. Medical training has always been directed, primarily, toward the solution of individual problems. The difficulties which psychiatrists have been called upon to face are largely those where emotional life is upset. The unit is the "personality." This term from our point of view can be defined as the individual with all his emotional and intellectual peculiarities trying to realize happiness and efficiency in the environment in which he lives. We are acutely aware that this definition is full of social implications of all sorts.

We believe that it is worth while to attempt a closer definition of psychiatry. We believe that the peculiar resources of the psychiatrist fall into two groups. In the first place, there is the attitude or point of view and in the second place there are the technical resources. As everyone knows, the variety of technical resources is great and the differences between them are deep-seated.

We believe that the attitude of those psychiatrists who can be expected to help children is of primary and fundamental importance, using both these much abused adjectives with respect and accuracy. The attitude of the psychiatrist is based on several convictions. He believes that a persistent eager curiosity directed toward the personalities of developing children, with attention to educational and social implications, will reveal, with very considerable accuracy, certain assets and liabilites which can be controlled. The evidence that trouble is ahead can be considered and alterations in procedures suggested. The psychiatrist believes that much of the "maladjustment" which leads to

friction and unhappiness can be understood before overt acts bring severe and often ineffective measures of "discipline" into play. The psychiatrist faces the whole situation which exists and tries to find how the difficulty began. During his patient search for a motive and for a solution he maintains an attitude of respect for the child, and views the future as optimistically as he can, realizing that pessimism means defeat. While he is studying the situation the psychiatrist can hardly inject attitudes of indignation or make useful decisions as to whether conduct, whose genesis still puzzles him, is "right" or "wrong."

The members of this Subcommittee know that this attitude is misunderstood by many people who think that psychiatrists have set themselves the task of making the world a place where children are expected to "express themselves" without "inhibitions" or "discipline" or unhappiness. As a matter of fact, none of the psychiatrists doing valid work with children is aiming at any such organization of the community nor does the psychiatric idea of the millennium include a population of placid well-adjusted, non-competitive units.

The intelligent psychiatrist regards struggle and unhappiness and even limited failure as vivid and often promising evidence. The over exhibitions of maladjustment which are called "delinquency," "truancy," "school failure" or "disobedience," he regards, not as evidence of reprehensible defiance of moral or educational codes, but as signs that the child has not found a simple and effective way of meeting the world in which he lives.

This is as good a place as any other to admit that many, if not all, effective psychiatrists give their first loyalty to the individual under their care. In no other way can they help him in solving his problems. The members of this Subcommittee are quite ready to admit that wholehearted individualism of this sort may be socially inconvenient. On the other hand, they feel that the very fact that psychiatrists in general are not parts of the educa-

tional or other machinery gives them an absolutely essential independence. This admission leaves them free to accept the refusal of courts or schools or parents to put their plans into action without any particular feeling of frustration. It is, however, interesting and important to ponder over the methods by which psychiatrists try to reconcile their extreme individualism with the necessity for cooperative solution of most of their clinical problems.

As we have stated, the psychiatrist or the psychologist who is attempting to straighten out difficulties of adjustment must necessarily be tolerant, at least for the time being, of deviations of behavior which are ordinarily viewed with disfavor or managed by disciplinary measures. The presumption, in his mind, is almost automatically in favor of the view that the management of the child has been unwise. No matter how cautious he may be he cannot possibly do his work without coming into conflict at frequent intervals with people whose views seem to him archaic or even silly. Frequently he comes up against social prejudices which completely block logical and promising solutions.

There are unquestionably a few people, doing psychiatric work with children, who go along watching the reactionary parent, the sentimental teacher, the inflexible policeman on the corner and the rest of the human environment as phenomena to be observed with dispassionate interest. Most of them, however, try to change matters a little, either by argument with the individual who blocks adequate measures, or by stirring up public opinion in favor of their own point of view.

We have watched psychiatrists, including ourselves, in this dual rôle of extreme individualist in regard to the patient, and of social reformer as far as the human environment is concerned, with mingled emotions. Basing our statements upon the wholly preposterous procedure of reading between the lines of our correspondence we have noticed the following ways of meeting the difficulty:

1. A few people, chiefly those in the group who apply psychoanalytical technique, think that they do not have to meet the difficulty at all. They undertake cases where the parents accept, in advance, certain definite obligations, and they work in such a way as to make the child capable of getting along even in unfavorable environment. It is, of course, perfectly evident that this method is not available for very small children and that its application must be confined to those thoroughly trained on psychoanalytical procedures. The theory that they can get results without cooperation with many people is not clearly proved, nor is it put forth with conviction.

2. It is quite possible to develop an organization where the investigator is working in a protected environment. His recommendations are given to those with authority to carry them out and he is spared from the necessity of interminable discussions with uninformed and hostile people. The typical example of this protected method is the diagnostic clinic whose authority comes from a court and whose therapy is done by various organizations whose workers are justly confident of the validity of diagnosis and advice given by the clinic. This freedom from the necessity of defending each decision to a new group of skeptics does not come without years of labor in earning prestige by valid work.

3. Another way out, which seems to offer promise, is to build up prestige by suitable mass distribution of information, so that the general public will understand and accept what is going to be done. It is not necessary to emphasize to the members of this Section that this method is the strictly orthodox American procedure. The psychiatrist who relies on prestige established by

propaganda is apt to find that certain rather important people have not been convinced of the validity of the method. He is then deprived of his hoped for protection, and is again forced to defend a series of experiments and is again constantly forced to shift between scientific observation and advocacy of a point of view.

4. The individual practitioner of medicine can, if he chooses, avoid most of these difficulties. If he is accustomed to give consideration to all troubles of children under his care, he will not be forced to insist upon the obvious fact that the intellect, the emotions and the body all need to be investigated. Neither he nor the parent nor the children will ever have had any other idea. On the whole, it is obvious that a great asset of the individual practitioner is that he is protected by the already existing prestige of medicine which can be strengthened by earned prestige as an individual.

Psychiatrists and practitioners of medicine in general will always be interested in the struggle of the individual to find his place in a society necessarily controlled by people who value conformity. On the whole they will be interested in the rebel or the deviate, whether the rebellion or deviation is against the shifting standards of physical hygiene or against the tentative principles of mental hygiene. They ought to be able to acquire two points of view. In the clinic or in the consulting room a rigid concentration on the individual problem is essential. When, in optimistic moments, they attempt to alter social attitudes they might as well recognize that their opinions will be regarded with respect, with skepticism, with sentimental awe or with frank indifference, depending upon the individuals in the audience. Their position will be enormously strengthened as soon as they can successfully defend the proposition that their public utterances represent the

attitude of enlightened doctors of all sorts. Until that time comes, those of us who expect to change public attitudes should recognize two perfectly straightforward methods. The conservative, traditional method is to prove by experience the validity of a procedure. This involves the demonstration that advice is good by presenting results. The success of "child guidance" cannot well be proved until a generation exposed to it has arrived at maturity.

The other procedure is to show that the methods suggested are logical and promising. When we argue on this basis we ought to treat the whole matter with a relatively light touch and not start out with the theory that we have an exclusive authority or an accepted body of fact to rely on.

The *technical resources* of *psychiatry* and *psychology* are, in our judgment, far more specialized matters. We can trust intelligent and interested doctors to use the attitudes of psychiatry beneficently. We are less agreed as to the value of the more technical resources in the hands of the general practitioner. Obviously there are details of physical examination, methods of testing intelligence and so on which are reliable only when performed and interpreted by specially trained individuals. Aside from details, however, there are wholly irreconcilable schools of psychiatry. Into the controversies involving strictly orthodox psychoanalysis versus all comers, or other less important points of difference it is not possible to go.

We all agree that a fundamental attitude of patient, optimistic, tolerant and respectful interest in the personality of the child is the basic asset of the psychiatrically intelligent doctor as far as child guidance is concerned. Without this, no technique will make him a safe and resourceful adviser. For the purposes of this discussion we are urging the validity of the psychiatric point of view, leaving discussion of the specific technical resources to be taken up by those who are willing to investigate the whole subject more adequately.

Any series of definitions which suggest that psychologists, because their chief interest is in trends, do not focus their attention upon individuals is upset by the existence of the "clinical psychologists." These workers define clinical psychology as the comprehensive study of the individual. From the medical point of view the choice of the word "clinical" is unfortunate since it implies a medical procedure or outlook. However, the clinical psychologists simply take up the study of the individual using the attitudes and techniques of psychology and education instead of those of medicine. This group, relatively small in numbers, is decidedly important, since its existence emphasizes the fact that the intellectual and emotional difficulties of individual children are not necessarily to be studied by medically trained people. Further, within the field of education there are a number of psychologists, or persons with psychological training (not clinical psychologists), who are engaged in the practical handling of individuals. In addition every teacher with modern training has had some background in psychology.

Just as some psychologists are primarily interested in individuals so certain psychiatrists are primarily interested in groups. Certain "mental hygienists" have taken the attitude that careful study of the field of medicine has revealed measures by which misconduct and maladjustment can be prevented on a grand scale. The study of children is of outstanding importance in their eyes because it leads to understanding of insanity and crime and suggests preventive measures. The members of this Subcommittee are all impressed with the hopeful aspects of this attitude. For the purposes of this report, however, they are unwilling to suggest that general practitioners and pediatricians should feel that they are called upon to diminish the incidence of the serious disorders which lead to complete social bankruptcy. "Mental Hygiene" from our point of view is a relatively simple matter. We regard "mental hygiene" as an effort to study the genetic factors which

influence personality with the hope that difficulties can be foreseen and evil consequences can be avoided. On the whole, we see every reason to hope that certain valid procedures, now utilized by a few highly trained persons, can be brought into widespread use. We confidently expect that much of what is now special knowledge will be incorporated into "common sense" in child rearing.

If we accept the fact that two leading groups exist, one, psychologists with education of groups their chief interest, and the other, psychiatrists with individual distress as their main preoccupation, we have by no means covered the ground.

In the first place, there is no possible way of excluding anyone from the field. Anyone can attempt to bring up other people's children. Teachers are obviously in the field. Judges are inevitably in authority, and so on. An attempt to cover all possibilities is doomed to confused failure.

There are, however, a few reasonably well-defined groups with clear relations to psychologists and psychiatrists whose field can be discussed.

The psychologist has had a profound influence on education. The natural consequence is that many university chairs of education are occupied by psychologists. Of course, a certain number of teachers are instructed in clinical psychological methods and all teachers have general psychological training. Even without the stimulus of special instruction certain teachers become especially interested in "problem children," in "parent education" and other more or less vaguely limited fields. Such interest may lead to positions as "visiting teachers" with duties which in some cases are almost identical with those of psychiatric social workers.

In another field, the psychiatric social worker, trained originally as an assistant and field worker for psychiatric clinics, may well feel interested in particular problems which she believes can be approached without direct psychiatric supervision.

From the narrow medical point of view it might appear that the present confusion in regard to leadership could and should be solved by a successful drive for exclusion of all non-medical individuals, just as those who intend to deal with physical disease are required to undergo specified curricula or to abstain from practice. Without going into the merits of such an idea, it is of course entirely impractical. No physician in his senses wants to undertake the whole of education in its widest sense and unless the entire field is taken over conflicts of jurisdiction will occur at every conceivable point.

The only possible solution is to define certain portions of the field in which medical attitudes and techniques can be expected to give good results and demonstrate the efficiency of suggested procedures.

DEFINITION OF FIELD

Nobody seriously questions the propriety of medical supervision of abnormal people who require segregation in hospitals for the mentally incompetent. Society has, however, kept ultimate control of these individuals in the hands of judges and other non-medical authorities. The study of personality in courts, in jails and in prisons is properly delegated to men and women who have had specialized training. On the whole, psychiatrists are likely to be in charge since the problems often involve ability to establish diagnoses of frank mental disease. Psychologists and sociologists have authority in certain aspects, particularly in the conduct of research. In any case, the general practitioner of medicine is not involved.

When socially less pressing problems of individual distress are considered the doctor is left to demonstrate his aptitude without acknowledged support by public authority.

The general practitioners and the pediatricians, who have been taught to divide human ailments into organic and functional with all emphasis on the former, are faced by a very interesting situation. On the whole, they have

not been particularly involved in the preliminary investigations of the new field and are caught almost unawares by a growing public interest in the promise of the new medical approach. The members of this Subcommittee would like to believe that this confusion is purely temporary and that doctors in general would soon adjust themselves to the new situation and cooperate in defining their opportunities.

It is perfectly clear to us that the general practitioner can occupy a position of great dignity and power in any adequate program. In so far as the subject is regarded as a medical one he is the one who is first asked for advice. His attitude at the outset may have a profound bearing on the adequacy of treatment, even if he chooses to refer all cases to those more eager to treat them.

In order to organize an adequate medical service of which general practitioners are integral parts, it is necessary to convince all parts of the team that the psychiatrist can have the same relation to the practitioner in general as any other specialist. This conviction on the part of the general practitioner can hardly be developed without preliminary evidence that psychiatrists are willing to cooperate in the usual ways with doctors at large. It seems clear that, at present, psychiatrists are a rather isolated group as far as medicine is concerned. Many of them are in closer contact with teachers and social workers than with the profession at large. We believe that progressive isolation is a very genuine peril.

This tendency toward isolation can be checked in various ways, or it can be accelerated. It is evident enough to all the members of this Subcommittee that the danger of isolation will be reduced as adequate instruction in medical schools is provided. Considering the fact that psychiatry as it now exists is a development of the present century, the following table is extraordinarily interesting and, from our point of view, both gratifying and disturbing.

CLASS A SCHOOLS REQUIRING COURSES IN PSYCHIATRY *

School	Hours Required
University of Arkansas School of Medicine	66
College of Medical Evangelists	103
Stanford University School of Medicine	98
University of California School of Medicine	48
University of Colorado School of Medicine	43
Yale University School of Medicine	None*
Georgetown University School of Medicine	105
George Washington University Medical School	38
Howard University School of Medicine	132
Emory University School of Medicine	121
University of Georgia Medical Department	206
Loyola University School of Medicine	60
Northwestern University Medical School	22
Rush Medical College	96
Ogden Graduate School of Medicine	None*
University of Illinois College of Medicine	24
Indiana University School of Medicine	89
State University of Iowa College of Medicine	None*
University of Kansas School of Medicine	88
University of Louisville School of Medicine	32
Tulane University of Louisiana School of Medicine	Short Course
Johns Hopkins University School of Medicine	56
University of Maryland School of Medicine	Short Course
Boston University School of Medicine	150
Harvard University Medical School	59
Tufts College Medical School	Short Course
University of Michigan Medical School	128
Detroit College of Medicine and Surgery	72
University of Minnesota Medical School	111
St. Louis University School of Medicine	152
Washington University School of Medicine	83
Creighton University School of Medicine	95
University of Nebraska School of Medicine	159

* Compiled by the Council on Medical Education and Hospitals of the American Medical Association in January, 1931. Medical schools offering only two year courses are not included.

CLASS A SCHOOLS REQUIRING COURSES IN PSYCHIATRY
(Continued)

School	Hours Required
Albany Medical College	114
University of Buffalo School of Medicine	88
Columbia University College of Physicians and Surgeons	125
Cornell University Medical College	65
Long Island College of Medicine	30
New York Homeopathic Medical College and Flower Hospital	64
University and Bellevue Hospital Medical College	52
University of Rochester School of Medicine	Two Years
Syracuse University School of Medicine	144
University of Cincinnati College of Medicine	52½
Western Reserve University School of Medicine	80
Ohio State University College of Medicine	58
University of Oklahoma School of Medicine	24
University of Oregon Medical School	66
Hahnemann Medical College and Hospital of Philadelphia	110
Jefferson Medical College	115
Temple University School of Medicine	Clinical
University of Pennsylvania School of Medicine	32
Woman's Medical College of Pennsylvania	None**
University of Pittsburgh School of Medicine	66
Medical College of the State of South Carolina	98
University of Tennessee School of Medicine	35
Meharry Medical College	32
Vanderbilt University School of Medicine	55
Baylor University College of Medicine	54
University of Texas School of Medicine	120
University of Vermont College of Medicine	None**
Medical College of Virginia	96
University of Virginia Department of Medicine	56
University of Wisconsin Medical School	120
Marquette University School of Medicine	32

** Courses offered in psychiatry but none required.

All medical schools practically speaking, in their catalogs, give time which is labelled "Psychiatry," and which is as much or more than many of the schools with adequate, well known courses of psychiatry. That is, the challenge to the medical schools to provide more hours in psychiatry is met as far as catalogs are concerned. The quality of teaching and so on is another question. We realize that hours of instruction assigned to psychiatry do not necessarily indicate adequate teaching, but they certainly prove that the faculties of medicine throughout the country are aware of the importance of the general subject. The figures given are distinctly chastening to those who have assumed that further emphasis in medical schools was the next step. On their face they show that such universities as Johns Hopkins and Harvard, where psychiatry has been recognized as a dignified and productive field for years, give less time to the subject than the majority of medical schools. One of the members of this Subcommittee has checked these figures by reference to catalogs and by informal investigation. It is obvious that the figures include, in many cases, time spent in the study of neurology. If the hours of teaching are actually used by psychiatrists the quality of instruction may well be investigated. The members of this Subcommittee acknowledge that these figures surprise and disconcert them. An obvious challenge is presented to psychiatrists to show how more time in medical schools is to be used.

In any case, it will be some years before all medical graduates have been exposed to adequate psychiatric instruction and experience. Since this Conference is particularly interested in the next decade it seems pertinent to attempt to indicate the difficulties which will exist in that period.

In the first place, there are a great many people who are in a tremendous hurry to get immediate results. These propagandists believe that methods are available which should be put into widespread use without delay. Some

of them are willing to apply the term "classical" to forms of organizations which they believe are of permanent value. The following statements are made: "So far as I am concerned, the psychiatrist, clinical psychologist, and psychiatric social worker represent a unit, the classical clinical unit in the whole field of active therapeutic work in mental hygiene." Another experienced individual says: "I think psychologists and teachers can and should help the psychiatrists in ways which the psychiatrists will have to discover by experiment and experience."

Statements of this type suggest that leadership is established and that methods of approach are standardized. Furthermore, the use of the term "classical" suggests that the procedure is not only correct for the moment but that most competent people agree that it is correct and expect it to remain in essentially its present state. Every medical member of this Subcommittee has worked with psychologists and with psychiatric social workers. We are all of us familiar with psychiatrists. We are by no means agreed upon the idea that leadership of a team of three or more, places the psychiatrist in the most favorable position. At least one medical member of the Subcommittee finds it possible to do his own "psychology," another regards his psychological colleague as an equal, working in a related field. The place of psychiatric social workers, now and in the future, seems to us so controversial and so interesting that we are including in our Appendix a full statement of their position.

A far less definite and more easily defensible position is taken by one of our psychological correspondents:

> I am not sufficiently close to this problem to speak with authority as to details, but the central fact is so obvious as to be readily statable. It seems to me unfortunate if administrative matters require formal definition of "psychology," "psychiatry" and "pediatrics"; or if they require a formal decision as to whether there should or should not be another class of persons who might

be called "mental hygienists" or "child guidance experts," "child mental hygienists."

It seems to me quite plain that the typical member of the formal groups already established is not sufficiently qualified for such special work, because the work requires either cooperation between these groups or a blending of the knowledge that pertains to each group. With human limitations as they are, the blending of this knowledge in any one individual means also a selection of it.

The typical psychologist will not do, but this specialist should have general psychological knowledge, especially the knowledge of the educational psychologist. The psychiatrist will not do, but this specialist should have the knowledge and attitude of the psychiatrist when he advises wisely in cases of maladjustment where mental disease is not indicated. The pediatrist will not do, except as he is psychologically sophisticated.

It seems to me that there ought to be a way of allowing persons with special aptitude to absorb the skill and knowledge of such disciplines where it is relevant, and of encouraging such specialists to take the leadership in this field. A wise and responsible person of this sort will know enough to seek more special advice where his own sophistication is inadequate.

If the professional castes are likely to hinder such an obviously correct procedure, then it may be necessary to give these persons a name and certificates of qualifications in order to get the best work done.

This suggestion, which is theoretically sound enough, becomes somewhat disturbing when a definite attempt is made to carry it out. Plans are already under way in at least one university to turn out child guidance experts without an adequate preliminary professional training in medicine, in psychology or in education. The members of the Subcommittee view this plan with frank misgivings but are quite aware that, in the absence of intelligent and widespread interest in the problem by physicians it is unreasonable to declare such an attempt impractical. It seems to us that such a plan offers diluted psychology and psychiatry without the maturity of judgment which is one of the assets we associate with true professional training.

This brings up the controversial question, "What is an expert?" We rely upon our Latin to support us in our conviction that "experience" is an essential element. No matter whether psychology or medicine or education is the basic "discipline" we believe a short course of technique needs a basic scientific experience of some solidity.

We admit that up to this point we have confused rather than clarified the issue. If it were practicable to publish our whole correspondence or to present stenographic reports of our conferences we believe that our hearers would marvel at the clarity of our presentation.

The situation can be summarized as follows: A fascinating field of study involving the personality of the child has been opened up. By its very nature it has attracted an extraordinary number of people of all sorts. Education, the study of crime, prevention of disease, sheer sentiment and scientific investigation are all involved. A certain amount of struggle for personal and group prestige is mixed in. Supposedly clear-headed efforts at scientific progress are tangled up with efforts to arouse public interest.

The very confusion of the subject is one of the best reasons for hoping that general practitioners and pediatricians will undertake the task of acquiring an intelligent attitude and an effective working technique.

We are willing to offer this challenge and this opportunity to doctors caring for children. If they cannot give intelligent advice upon the difficulties which threaten the orderly and satisfactory development of personalities in children under their charge they will be forced to accept a status which will deprive them of many opportunities to help their patients and will inevitably render their practice less vivid and less interesting. On the other hand, a serious and eager interest in this confused field cannot help increasing their value to their patients and will open up new and profitable opportunities for service.

To psychiatrists, psychologists and the rest of the individuals who are studying the emotional and intellectual

difficulties among children we offer the following ideas for consideration. The doctor in charge of the health of children is in a position of great natural power. He can help or hinder any program to an extraordinary degree. The theory that valid advice is not frequently given by the doctor who has had no special training in psychology and psychiatry is not tenable. Much of the information which a formal clinic collects by the efforts of various workers can be assembled by the alert general practitioner without difficulty and without organization. We believe that efforts to cooperate with him are well worth making. Admittedly such efforts need to be directed with great intelligence. Sophisticated doctors have been appalled by certain propagandist statements. They have learned by experience to distrust slogans. They have been asked to help and then repelled by extortionate demands upon their time when they offered to learn to help. They have seen clinics operated on the theory that psychologists and social workers could settle problems of medical importance among their patients without their aid. Many of these difficulties are superficial but they pile up and tend to isolate psychology and psychiatry in a way that is unfortunate. The technique of propaganda and instruction is decidedly faulty and should be studied with prayerful eagerness.

This prolonged introduction indicates the difficulties which exist. It is now possible to survey with some accuracy the questions which are supposed to get an answer from the deliberations of this conference.

EXTENT OF PROBLEM

There seems to be no doubt that every child should be under medical observation. Unless the whole theory of preventive medicine is absurd there are valid procedures which can be applied only after competent medical examination of each child. The members of this Section are not upset by this statement. In the course of each child's life certain questions, not soluble by drugs or inoculations or

scalpels, are propounded by parents to doctors. The most rigid materialist cannot avoid advice as to school, habits and so on. To this extent the problem of mental hygiene is universal. Neither does anyone object to the idea that education is to be imposed on all children and that the process involves by its very definition the constant facing of problems of adjusting a developing personality.

The obvious and easy suggestion is that *all* children should be under the care of specialists in psychiatry. We have a lively fear of two phrases remembered from the days when logic was regarded with deep respect in the educational scheme. One way, and a perfectly fair one, by which to demolish the validity of a syllogism was the *reductio ad absurdum*. Even with "classical teams" and even further methods of distributing and diluting labor we cannot conceive of a situation where enough intelligent people could be persuaded to perfect themselves as psychiatrists or a community so wealthy and so self-depreciatory that it would support and accept the service offered.

The other method of demolishing a logical suggestion is regarded with abhorrence by logicians but with respect by politicians. The *argumentum ad hominem* or abuse and ridicule pure and simple, is often effective. We have some knowledge of the extreme difficulty with which wise, tolerant, eager people with adequate training, are found for a few organized psychiatric clinics. We are perfectly ready to join those who are willing to dismiss the idea of universal specialized psychiatric supervision on the grounds that any psychiatrists who would try to run the world are not the ones who could do it.

The extreme suggestion that *all* children should be under the care of psychiatrists is, of course, a purely theoretical one. A more serious one which has the authority of a subcommittee of this Conference behind it is that one child in three *needs treatment* under psychiatric supervision. A little calculation with census figures before us

would probably tell us whether a problem of psychiatric interest is found in every family or in only every other family. The exact reasoning by which this conclusion is reached with rigid definition of terms would have to be presented before this Subcommittee would attempt defence of this estimate.

An estimate by teachers, also reported in this Conference, discloses that some of them get into serious trouble on account of "emotional instability, nervousness and delinquency" in school children about once in twenty-five times. Again a very painstaking study would be needed for any adequate appraisal. The complication is not lessened by the fact, pointed out with great force by Wickman, that psychiatrists are disturbed, not by children who upset school routines by rowdiness, but by the reactions of children who are inconspicuous and frequently very docile. It is thus perfectly obvious that the selection of children as well as their total numbers would vary, depending upon the individual making the choice.

In any case what all the figures show is that there is a very large number of children whose progress is viewed with anxiety by psychiatrists and by teachers and that this anxiety is being communicated to parents. In the natural course of events, the impact is being transmitted to doctors in general.

At this point a few frank doubts occur to all the members of the Subcommittee. The urgency of these doubts and the reaction to them is not identical in type or in intensity since we were selected to represent various points of view.

Is the whole subject confused because many people haven't kept clear heads and used words accurately? On the whole, this Subcommittee believes that mental hygiene, of a resourceful type, is one thing and psychiatric treatment is another. In the same way, we have seen many people supporting arguments for sensible educational schemes by referring to prevention of entirely irrelevant mental diseases and serious delinquencies.

Second, we are by no means convinced that the young science of modern psychiatry has proved its right to intervene in every case where children are making heavy weather of their education. In this connection we believe that a great many "problems" are quite soluble by simple measures, directed at obvious difficulties and that wisdom often dictates a "hands off" policy as far as searching and prolonged investigation is concerned. We are quite conscious that "over solicitude," which we, like all sensible people, regard as undesirable, may be fostered by over eagerness to discover hidden causes of trouble. We trust that restraint, a peculiarly difficult attitude for the pioneer, will become a routine virtue as the science of psychiatry grows to maturity. Meanwhile, we recognize that among certain groups of parents it is the fashion to try to shift burdens of responsibility to the eager shoulders of certain psychiatrists. This phase of the problem is presumably transient, it affects very few people and can be left to itself without too much anxiety as far as the children are concerned. Any considerable effort to shift all responsibility will overwhelm the few individuals willing to accept the load.

Anyone who compares the typical primer for parents on "child psychology," "child guidance" or other more or less formidable titles, with actual practice, can see why certain parents believe that "science" has proved its right to pinch hit for the home where difficulties get bothersome and why some psychiatrists cannot help them. There is a type of parent who gets a real thrill out of the discovery that it is "wise" and "scientific" and "right" to appoint a corps of deputies. All the members of this Subcommittee disown the slightest interest in the "American home has broken down" and "Science has shown a better way" type of argument. No valid scheme of mental hygiene with which we are familiar makes parenthood a less responsible and less anxious job. All we hope for is that certain predictable difficulties can be foreseen and that energies and devotions

can be more wisely directed as a result of the labors of psychologists and psychiatrists.

With the full recognition that adequate discussion of this problem would bring in considerations of many types, we wish to emphasize the point of view expressed by the Delinquency Committee in its report before this Conference.[1] They pointed out that the conception of the child as an isolated individual with a limited and specific environment was untenable, and they described the child as a part of a social fabric inextricably connected with his total social universe.

This Subcommittee believes that the study of an individual distress is the logical concern of the doctor. Those of us who are responsible for "child guidance" are obviously going to become involved with fields of effort where our status is not clear. Education and psychology are sciences or "disciplines" with definite traditions and techniques. "Social science" has a definite meaning to some individuals. When doctors enter these fields they have no right to attempt to lead or to dictate simply because their prestige as physicians gives them an advantage. The attempt to carry prestige beyond the field where it was earned is the cause of most of the confusion which exists. Doctors are flagrant offenders, psychologists have not been guiltless and teachers and the clergy have furnished their share of examples. The medical profession and its attitude are our direct concern. As physicians we can investigate the situation and make our own disclaimers of expert knowledge. At times we should be prepared to lay aside the mantle of authority and enter the field with all comers. There may be corners of the domains of education, psychology and social science where we can establish positions by earned prestige in a new field.

If we, as physicians, enter the other fields without arrogance and without claiming leadership we can view

[1] Report of the Committee on Delinquency, Section IV, C 2.

with interest and without too much anxiety the infiltration of outposts of medicine by non-medical individuals.

PRESENT PROCEDURE

Organized Clinics for Children

We have surveyed the present efforts in the field of "mental hygiene" or "child guidance" with great interest. Figures are being collected and efforts are being made to grade various clinics by highly qualified experts under other auspices. In 1928 a survey by the National Committee for Mental Hygiene showed 355 clinics staffed by 529 psychiatrists, 300 psychologists, and 344 social workers who cared for 44,296 children.

These figures are, of course, impressive. At a rough estimate one might say that one supervisor was equal to the task of resolving the difficulties of 40 children a year. Nobody who has watched clinics of this type would think of trying to make the figures support any such statement. The idea that all these clinics are intended to solve problems at a specified rate is entertained by no one who is familiar with them.

In an Appendix to this report brief descriptions of various types of clinics are reported. It is important to note, in this connection, that spokesmen for such well known organizations as the Judge Baker Foundation in Boston, and the Institute for Child Guidance in New York specifically state that investigation, research and teaching are their major preoccupations. When the situation is studied more closely it is quite evident that much of the therapy in *all* clinics is left to parents, teachers or social workers who have been enlightened by the accurate and painstaking investigation of the group.

We suggested earlier in this report that the organized group must obtain social and economic information from workers sent out from the clinic, whereas the adequately

trained practitioner might easily have the information sought. In any case the individualist who sees the formal group at work is impressed by the initial dismemberment of the problem and still more impressed by the final synthesis of the information obtained. As a device for research and teaching the method has enormous advantages. As an ideal for universal application it has evident disadvantages.

If the various human units involved in supervision were more or less standardized, and if the human units under review were standardized at all, we could assume that a given number of groups, consisting of psychiatrist, psychologist and psychiatric social worker, for example, could be obtained to cover the needs of a given number of children. We believe that no one could be found to defend the theory that any such precision exists. As a matter of experience the difficulty of supplying acceptable personnel is already acute.

We believe thoroughly that the accumulation of careful records and the training of workers justify the organized clinic as an experiment in medicine and in education. We are agreed that for the special needs of courts and school systems a group has definite advantages. We are not willing to go on record that the formal clinic has proved itself to be the only form of effort worth support.

The General Psychiatric Clinic

In many places university or state hospitals combine child guidance work with the routine supervision of cases of all ages. If reasonable segregation of different types of disorder is possible this method has many advantages. The relationship between disorders in childhood and later disability is kept in sight, duplication of personnel is avoided and a sense of proportion is fostered. Fortunately there is an increasing number of state-supported groups involved.

Psychiatric Work in Direct Connection with General and Children's Hospitals

The close relationship between general medical men and psychiatric specialists which results from association under the same roof is obviously of the greatest possible value. It seems to us that this development offers the best chance in sight, of bringing psychiatry into proper relation to general medicine. Among the advantages which stand out is the fact that students and house officers can be made aware of points of view and methods of approach.

The Supervision of "Psychiatric" Clinics by Physicians without Special Training is obviously possible. We believe that it is possible to find doctors who are psychiatrically intelligent, who can be trusted to give adequate advice to many disturbed parents, even if they have not had extensive special training. We are inclined to believe that individuals capable of directing such a clinic would be the first to refuse to make any such formal claim. We should be delighted to see pediatricians, aware of the numberless problems which exist, extend the field of pediatrics until it included much of the area now considered as psychiatric, but we can see objections, in the present state of knowledge, to supporting such individuals in the claim that they are conducting a specific and adequate "psychiatric" clinic.

Neurologists as Directors of Psychiatric Work are frequently found. A good deal of misunderstanding can arise here. There is, of course, no argument about the psychiatric competence of many men whose major interest is in organic neurology. We are aware, however, that many neurologists regard psychiatry as "functional" neurology, and that many of them see relatively few children. The question as to whether a neurologist is a competent psychiatrist for children cannot be answered by establishing his prestige as an expert in organic neurology.

The Possibility that the Individual Care of Children in Difficulties is not Medical in Nature is, of course, suggested. The clearest and most extreme statement of this point of view comes from a psychologist:

> In organized work, requiring the cooperation of specialists of various kinds, what is the proper method of group control? This depends on the direction of major responsibility. For child development groups, the major responsibility is psychological. The *handling* of the child is of maximal importance. Emotional factors, fatigue, habit formation and correction: these are the special premises of the psychologist who is a specialist in child psychology. Next comes the pediatrician. Not because the physical welfare of the child is not primary, but because the pediatric supervision is not continuous. The physical examination is a daily, not a constant matter, and the pediatrician and the psychologist work in perfect harmony. The other specialists who are necessary are still more periodical. Those who are not necessary, but are interested solely in the research side, must, of course, subordinate their needs to the psychologist and the pediatrician. The psychiatrist has no field at all here, unless, like the dentist or the oculist, he is specifically called in by the pediatrician.
>
> Under any other type of organization, child development work is not only scientifically handicapped—it is an actual danger to which we have no right to subject the child.

This Subcommittee does not agree but it is acutely conscious of the fact that a persistent attitude of indifference on the part of the medical profession may shift the burden of proof. At present the medical profession is regarded by most people as the natural source of advice. Obviously, it seems to us, doctors can acquire relevant psychological and educational attitudes and techniques more safely than psychologists and teachers can acquire adequate medical assets. We should view with distress and misgivings the transfer of supervision of children in difficulties to individuals without medical training, but we are not at all sure that the experiment will not be tried upon a considerable scale. Certainly we have no desire, as we have no right, to

block well considered and honest experiments along these lines.

It would be possible to extend this list of more or less formal attacks on the problem by including projects ordinarily classified under education, but it would be a rather futile proceeding unless we were prepared to discuss educational methods in general.

We are willing to defend the statement that all the organized groups where psychiatric leadership is accepted and all the specialists in psychiatry can care for only a negligible number of children. Their major function is to investigate conditions, to establish facts and to devise methods by which appropriate instruction can be available to all parents whose children are failing to meet life adequately and happily.

In a measure such instruction can be profitably given directly to parents and teachers. But in larger measure, the interpretation and the utilization of the advances in psychiatry and psychology by parents demand the intervention of a skilled and resourceful advisor. We believe that the problem will never be adequately solved until a very considerable number of general practitioners and pediatricians become psychiatrically intelligent and educationally sensitive.

The attainment of this intelligence and this sensitiveness depends, in part, upon sheer hard work. We have no simple formula nor any convenient packages of techniques. We make the following general suggestions as to the place of psychology and psychiatry in pediatrics, or in general practice.

PLACE OF THE GENERAL PRACTITIONER

The observation and wise supervision of the development of the personality of the child are of obvious importance to the doctor. In the first place, personality is decidedly interesting in itself and in the second, it is an essential element in forecasting and controlling the course

of physical disorder. Obviously, this statement is simply paraphrasing the old saws about the veteran physician knowing the constitutions and temperaments of his patients. We are by no means certain that the traditional family physician did not and does not practice a very high type of mental hygiene. We are sure that, informally, many pediatricians devote effective attention toward the personalities of children under their care. It is thoroughly apparent, however, that wise doctors of this sort are not by any means universal and that it is not easy to appraise their methods.

We feel quite sure that the physician who is in charge of a child from birth to puberty could improve the quality of his service if he made a conscious and regular effort to gain information on the following points:

1. Are the parents aware of the changes in emotional reaction and in intellectual capacity that occur with advancing years? Are they reasonably familiar with the best way of managing such common difficulties as enuresis and masturbation? Are they setting sensible and attainable goals for their children? Do they on the whole realize the implications of "growing up" and the difficulties that must be faced if "maturity" is to be more than a chronological period of physical growth? Does the available evidence indicate that the parents honestly want the child to grow up and become independent, or do they cling to authority and try to control the child to satisfy their own desires?

2. Is the intellectual progress of the child satisfactory? At intervals the steps of advance could be recorded along with weights, heights, vaccination and the like. Such a routine would prevent a vast amount of distress and reveal educational difficulties before anxious and often ineffective pressure has been exerted. Obviously, such a method would naturally lead to intelligent impressions about local educational enterprises. All doctors withdraw children

from school from time to time. The difficulties incident to prolonged illness and convalescence can be far more wisely handled if the doctor has reasonably close knowledge of the educational problems he and the disabilities are creating. It seems to us quite clear that the general practitioner or the pediatrician who does not bother with education, except to block it by withdrawing children from school, from time to time, is unsound as a general advisor.

3. The child from early months on is interested in what goes on about him. It is obvious that even young children understand a good deal of the conversation that goes on in a doctor's office. The doctor and parent who ignore a child except as a lay figure on whom physical procedures are imposed lack imagination, and, of course, that is only another method of saying they are practicing bad mental hygiene. In dealing with adults, doctors are almost uniformly careful to convey an accurate impression. It is obviously possible to convey an accurate impression to an adult and simultaneously to convey an entirely inaccurate one to the child. In this connection we wish to emphasize that words are not the only way in which ideas are conveyed. The tone of the voice, the expression and so on, definitely reveal irritation, despair or indifference to the child even if an elaborate vocabulary is supposed to confine the conversation to parent and doctor. Another element here is the fact that children's pride is often outraged by the procedures of mother and doctor. A relatively simple technique can be worked out to avoid this difficulty. All doctors have waiting rooms and there is no difficulty in dividing the audience at appropriate times. Even in purely physical diseases this may be important. When habits or misdemeanors are under review it is obviously imperative.

4. If the suggestions in the last paragraph are regarded with favor it is obvious that a child can often give useful information. This fact is not emphasized in children's hospitals where the heading "informant" is always

followed by "mother," "aunt," or "social worker" but never by "patient." If we were asked to indicate the single point that most clearly distinguishes the psychiatrically intelligent from the psychiatrically unintelligent physician we would agree that the former always tries to communicate with the child as well as with those in control of it.

The decision to discuss matters with a child involves no difficulties until we find evidence of friction between the child and other members of the family or between the child and the school. Yet it is exactly at this point that the conversation becomes interesting and important. The skilful physician does not allow himself to be manoeuvered into a false position. He makes it perfectly clear that neither side is entitled to betrayal of confidence. If he is at all clever at the game he avoids taking sides on any moral grounds and acts as a neutral observer until definite opinions are justified.

Under these circumstances he is in the position of an authorized busybody, collector of gossip and observer and appraiser of family skeletons. Obviously, it is highly useful to have already earned the confidence of the family by trustworthy activities in regard to measles and whooping cough. It is also rather less complicated to be an individual than to be one of a group. The data so collected chiefly concern the environment of the child. The question of collecting details of the emotional life of the child can then be considered. It is always worth while to see what happens when a child's difficulties are talked over confidentially and with respect. For one thing, the child may admit that he is unhappy and wants help. He may reveal easily remedied sources of misunderstanding. His behavior and attitude may explain quite clearly why he cannot get along.

If "lying" is revealed by discrepancies between the story told by parent and child a field of extraordinary interest is at once opened for investigation. On the whole,

persistent and purposeful lying is a signal calling for careful investigation. Its importance probably justifies discussion with the best available consultant since the interpretation and the handling of the situations responsible for it are decidedly complicated and mishandling may well deprive the child of help which is immediately and urgently needed.

In any case, after an interview it is possible to review the situation with parents. It is possible to find out very informally whether they have a reasonably intelligent attitude towards the physical and emotional changes which are characteristic of the child at the moment. It is also possible to find out the intellectual and social aims they are setting for the child.

After getting the available evidence together the doctor is in a position to act with some discrimination. Obviously, he will attempt to help the individual in trouble, but he will also be prepared to offer a solution fair to the whole family since the adviser who is wholly preoccupied with an individual may make a decision which is disastrous to all the other members.

The members of this Subcommittee feel that it is peculiarly appropriate for the general practitioner to guard the family as a unit against all possible difficulties. In the first place, the family budget supports him and the family loyalty is given him. The psychiatric specialist may, and sometimes does, miss the family in either of two ways. The intense study of the individual may leave the psychiatrist with a rather shadowy impression of the home, which unfortunately often remains one of the things he hears about but very seldom sees. On the other hand, when he considers environment he may feel that the school is a unit, the church is a unit, society is a unit, the whole cosmos is a unit as much as the family is a unit. In philosophic moments we would all subscribe to this broader and finer definition, but we can see that practitioners of medicine must limit their specific responsibility.

In managing the feeding and other habits of infants, in straightening out misunderstandings about sex, and in supervising prolonged illness, doctors inevitably influence personality. This Subcommittee has no desire to lay down a set of psychiatric aphorisms to rule the methods used. It does, however, feel justified in urging physicians to find out about the attitudes of psychiatrists concerning such things.

This Subcommittee is convinced that adequate medical service cannot be given without due consideration of intellectual and emotional factors. In the course of prolonged and varied correspondence it has discovered very few people who argued against this point of view. It, therefore, feels entitled to regard it as axiomatic that the subjects of psychology and psychiatry are of interest and importance to all medical practitioners who direct the medical care of children.

Beyond this point a wide divergence of views exists. We admit that teachers, psychologists and many others are involved, but it would take us far afield to go into points of view not involving doctors. From a strictly medical point of view there are two extremes among practitioners. At one extreme are experienced medical men who find satisfaction in dividing sick children into two groups. One group have physical diseases and should be treated with enthusiasm, persistence and optimism unless they are feeble-minded. The defectives are to be regarded as problems for the psychologist or psychiatrist. The second group are not afflicted by physical disease, but come under supervision because their habits or their upbringing or their teaching is unsatisfactory. To the parents of these children authoritative advice based on "experience" and "commonsense" is given.

At the other extreme is the doctor who recognizes that physical disease may exist but is perfectly ready to assume that any doctor knows enough to handle that. His interest is in the "whole child" or the "total personality." He

speaks with authority upon education, religion and so on, leaving his hearers with the impression that it is almost trivial to bother with adenoids, typhoid or tuberculosis.

Across an apparently unbridgeable gap protagonists of these two points of view glare at each other emphasizing all the differences between them and tending to prevent any clear discussion. As embattled defenders of obviously untenable positions both sides have tried to rally support. Facts, hopes and ambitions have become all mixed up.

The members of this Subcommittee believe that most of the confusion, which they frankly admit, is due to the fact that each of the extreme groups have ignored the contributions of those upon the other side and are intolerant of those who occupy the middle ground.

DEFICIENCIES IN PRESENT PROCEDURE

The obvious present difficulty in the situation is that there is no clear understanding as to the limits of the fields within which teachers, psychologists and doctors should exercise leadership. There is no validity in the notion that limits should be set by law and no excuse for believing that exclusive control, if possible, is desirable.

From the medical point of view an alert, well instructed profession sensitive to the educational and psychiatric implications of general practice, could clarify the situation. We hope that the rapid increase of psychiatric instruction in medical schools will lead the present students along roads of psychiatric sophistication.

Until the time comes when better training has been given to all doctors we shall probably live among a rather chaotic but stimulating series of experiments. Psychiatrists can be depended upon to maintain well defended outposts which will keep alive the principle that control of supervision of individual distress of all sorts is a medical matter. If an increasingly well informed medical profession approves of their efforts it is probable that an increasing

number of children will receive, as a part of their medical care, adequate attention to difficulties of adjustment.

The Subcommittee has attempted to find out whether the intelligent and generally well informed pediatrician is as bad as he is painted by the extremist among psychiatrists and vice versa.

Attitude and Practice of Pediatricians

One group frankly state that "psychiatry" is a technique and should be practiced only by those with specific experiences in the subject. The Subcommittee is impressed by the fact that those who hold this point of view have worked with psychiatrists and suggests that they are talking about the more serious disturbances. The thoughtful men who take this attitude are eager to see a group developed who combine the virtues of pediatrician and psychiatrist but realize their own deficiencies in the latter rôle.

A second group have confidence in their ability to deal wisely with most of the difficulties that come up. The clearest statement of this position is the following letter from the chief of an important department of pediatrics:

I have received your very interesting questionnaire and I will endeavor to answer the questions which it contained.

1. It seems to me that most problems that a pediatrician deals with have a psychiatric angle, and consequently only the more difficult cases he will have to refer to a psychiatrist. I also feel that the pediatrist should have a certain amount of training to enable him to handle the majority of these cases. He must develop a method in handling this part of the problem.

2. The pediatrist should refer only those cases which he cannot handle by himself. A doctor of our staff is available for this work, and he very frequently cooperates with us.

3. It has always been my feeling that the particular problem which you mention is one of the most important in determining a man's success in practice. No doubt, some men place more emphasis on this problem than others, but it is almost impossible to practice pediatrics without using it.

It is a little difficult to give you any definite information as to the use of the psychiatric approach in my experience. My first aim is to obtain the confidence of my patient and to make him want to do those things that are good for him in the treatment for an acute condition or in a regime of hygiene while he is well. Secondly to transfer that attitude to the parents in their relationship to the child.

A third group attack the validity of the whole conception built up by psychologists and psychiatrists and are whole-hearted in their denunciation.

Is psychiatry an attitude or a technique?

I think it is both. The technique is a schedule of pointer readings. The interpretation of those is an attitude. Speaking as a layman I feel that the psychiatrists and psychologists not only have not put their house in order on the theoretical side, but also have not finally shown that their technique is adequate to demonstrate the truths which they claim to have revealed. What I mean is this. As a man of ordinary education I have some notion of what, for example, the physicists are trying to do. Such notions as mass, action, entropy, and so forth, have some meaning to me. I do not mean that I am competent to appraise their technique, but when the technique is described I at least have some notion of what they are doing. Moreover, when they assemble their data and present it in non-technical terms I can apprehend, in a way at least, a scheme of things as a consistent whole. I can see that there is some relation, for example, between experiments on radioactive substances and the temperature of the interior of stars, but when I come to read the literature of psychiatry and psychology I can make practically nothing out of it. It is this unintelligibility that makes me wonder whether the psychiatrists' technique is, after all, wholly reliable.

Now concerning whether physicians without technical training are justified in studying human nature, the answer is clearer. I think that regardless of what psychiatrists or psychologists think doctors will continue to study human nature. No one can claim a monopoly of any field and if they are really interested in it the question of whether somebody else has the technique is not going to

bother them. They will probably develop their own technique as has been done in other fields by other men. Would they have said that Banting ought not to have worked on insulin because he was not primarily a diabetic specialist?

As to the justification in handling such problems as habit training, education, and so forth, I think the answer is simply that as these problems confront him the physician will continue to handle them in the future as he has in the past unless some legislative fiat prevents him from so doing, but that sounds like nonsense. In brief, to answer the question, psychiatry is an attitude with an associated technique and the physician has the right to adopt the technique which seems to him most appropriate for handling the individual case.

Should psychiatry be employed by the first or last person seeing the child?

Anyone who has ever seen any child must know that psychiatry will have to be employed first, last and all the time. If the psychiatrists think that every apparent mental difficulty should be referred to them I can only say that I think they must be entirely ignorant of pediatric practice. I think that altogether too much is made of psychiatry. After all the important disabilities are, for the most part, of a non-psychiatric nature although these may have their psychiatric features. It is not things like bed-wetting, psychiatric anorexia, father-daughter complexes, and so forth, that are disabling children. They are important enough, but the things that really cause anguish and suffering are organic diseases. At one time during the War it is reported that someone suggested to Lloyd George that the Cabinet should be replaced by a body of experts. His reply was: "Hang the experts. Give us a man." In the case of children the man is the doctor. He will consult psychiatrists when needed just as he consults surgeons, neurologists, ophthalmologists, and so forth.

There is the practical question of the availability of psychiatric specialists. I have found no one in this part of the world who has ever given me the slightest help. They will have to do better than this before I can see the wisdom of referring every child with any apparent mental difficulty to a psychiatrist.

How far do you feel that the general pediatrician is either willing or able to go in dealing with psychiatric problems?

Barring institutional cases and the more difficult "problem child" it seems to me that the general pediatrician is both able and willing to handle the psychiatric problems which come to him. The general pediatrician may not enjoy psychiatric problems but then it is very doubtful whether much of practice can be called enjoyable. The more difficult cases will require more expert advice than most of us are able to give, but the psychiatrist who handles such cases ought to be primarily a pediatrician who has taken up psychiatry rather than a psychiatrist whose knowledge of pediatrics is second-hand.

I have no particular book or technique which I am using effectively. Indeed, I was on the verge of writing you to ask if you could recommend to me some book, for it is a subject about which I should like to learn something if I could find anyone to teach me.

It seems to me that the whole problem is a manifestation of the struggle between two opposing groups. There are those who feel that the child should be cared for and trained by the parents, with the advice of physicians and teachers. On the other hand are those who, following the Russian ideology, would have the infant placed under the care of experts at birth and reared as a civic particle quite independent of the family. Perhaps this is what we are coming to, and into such a scheme the aggressive program of the psychiatrists and mental hygienists would fit very well. But even though psychiatry reaches the state of an exact science when it can predict behavior, emotional states and intelligence there remains the problem of deciding what the behavior and so forth *ought* to be. *Quis custodiet ipsos custodios?*

All the members of the Subcommittee know members of each of these groups. The interesting thing is that, outside of those people working in laboratories on purely organic problems, it has been unable to discover the pediatrician who confesses complete lack of interest in the problem.

The investigation of the other side of the question is equally interesting.

The Attitude of Psychiatrists Toward Pediatricians

The obvious desire of psychiatrists to enlarge the service which they believe they can offer leads them, first of all, to urge better psychiatric training. In so far as medical school courses are concerned the problem is being rapidly solved, at least in catalogs. A more exacting suggestion is the following:

> The medical graduate should be advised that in psychiatry there is the greatest untilled field in preventive medicine; in order to qualify for this field that he should have not less than a year's experience in clinical psychiatry in a mental hospital; in addition to that he should have an equal period in a child guidance clinic. With such training the graduate would understand the use of accepted and standardized mental tests, and would be prepared to give such tests and to evaluate them. He should have some knowledge of psychoanalytical principles and their application but should not, except with special training, attempt to do psychoanalysis.

It is comparatively easy to plan for basic improvements in medical education. At least we can assume a base line of preparation of fair constancy. It is infinitely more difficult to plan measures by which doctors in general can be kept in touch with progress in psychiatry. Of course, no considerable numbers of doctors are going to start at the bottom and develop into well-rounded and specialized psychiatrists.

We feel very strongly that the problem, though difficult, can be attacked rationally. Those general practitioners and pediatricians who believe that the supervision of the orderly growth of the child is one of the responsibilities that is included under medical care cannot escape consideration of the "personality." If they consider personality at all they should reject the contributions of those who are studying the subject with persistence and eagerness only after examination.

On the other hand psychologists and psychiatrists should be able to devise methods for meeting the reason-

able demands of doctors seeking information. In general they should be tolerant of the confusion which has been created, in part at least, by those within their own group who have not always distinguished between hopes and achievements.

The Subcommittee has no way of forecasting the fate of the various projects now being tested. The medical profession's share in the interesting job of child guidance will depend, not upon a few specialists nor upon a few elaborate clinics, but upon the existence of widespread and intelligent interest and participation by a large number of physicians. The only prophecy which we are willing to make is that a practitioner of medicine who ignores the personality of the children under his care will find his position as a family advisor in definite danger.

Just as we are unwilling to offer on behalf of psychiatry to relieve parents of responsibility, so we are not able to offer pediatricians a smooth and easy path toward the psychiatric and psychological sophistication which we would like to see them possess. We confess that the primers which have been published won't help them much and we have no idea that prolonged postgraduate training will fit into most programs of education for general practitioners.

If the efforts of psychologists and psychiatrists to teach have not been adequate there is every reason for pediatricians to devise methods by which they can select the techniques and the attitudes which will help them. The intellectual wares of the psychiatrists and the psychologists may not suit the buying habits of the practitioner of medicine but we are confident that among them are indispensable tools for medical men.

We cannot help having faith in the eventual ability of practiced and almost inspired borrowers of techniques and attitudes, as general practitioners have proved themselves to be, to select valid ideas. With all seriousness, we offer, on behalf of psychology and psychiatry, everything we

believe to be useful to doctors and ask is return that they prepare for the use of new ideas by intelligent consultation and adequate instruction.

CONCLUSIONS

The members of this Subcommittee are prepared to defend the statement that adequate medical care of the child cannot be given without intelligent attention to any intellectual and emotional difficulties which may be present. The fields of psychology and psychiatry are broad and rather ill-defined and we do not urge doctors in general to attempt to become expert in these subjects.

There is, however, such a thing as psychiatric intelligence which can be achieved by most physicians. The psychiatrically intelligent doctor is, in the first place, familiar with the people doing valid work in his community; in the second place, he is aware of the fact that the child has a personality as well as a body. The personality he defines in a way satisfactory to himself. To our minds the following definition is adequate for purposes of discussion: The individual with all his emotional and intellectual peculiarities trying to realize happiness and efficiency in the environment in which he lives.

When signs of difficulty arise the psychiatrically intelligent doctor is not bewildered by bizarre behavior or depressed by evidence of sin, but is curious as to motives. He recognizes that the motives can be discovered only by discussion with the child and by study of the human environment.

For an effective study of personality, to use a rather formal phrase for what is often an informal procedure, the psychiatrist needs two assets. First, he must have an adequate attitude. Patience, curiosity, tolerance and almost invincible optimism are essential. To this attitude technical resources of a more or less elaborate, but by no means standardized, sort are added.

The general practitioner must decide whether he regards the maintenance of the attitude as practicable. If he feels that his time table allows patient and often prolonged conversations he can begin to acquire technical resources. We believe that the technical resources of the doctor should be derived from those of psychiatrists just as the technical resources needed for urological study should be those of the urologists.

The members of this Subcommittee believe that if doctors in large numbers acquire psychiatric intelligence and become sensitive to the educational implications of the situations which arise in their practice, a new and effective service can be rendered.

It is quite clear to us that there is no uniform program which will be suitable. No one of us proposes to argue that the medical profession should dictate to home or school. Without question, the home and the school must do most of the work. Psychologists have established a very strong position as directors of education and doctors have no particular authority in this side of child guidance.

When trouble arises and the individual child is in distress a well informed and alert physician is the obvious adviser. Unwillingness of doctors at large to acquire the ability to deal wisely with problems involving the personality of the child may lead to transfer of this field to formal organizations or to individuals without medical experience. Such a solution will inevitably diminish both the prestige of the private practitioner of medicine and the interest of his job.

EXTRACTS FROM DISCUSSION

ESTHER LORING RICHARDS, M.D., D.Sc.,
Associate Professor of Psychiatry
Johns Hopkins University School of Medicine, Baltimore, Maryland

I wish to congratulate Doctor Crothers on the thoughtful, painstaking, and judicially minded manner in which he has gone about the presentation of material exceedingly difficult to correlate. From his efforts one gathers first of all that there is considerable disagreement among the sons of Zebedee as to who shall sit upon the right hand and who shall sit upon the left in that millennium of Child Health and Protection toward which we have all been struggling for the past year. If this whole White House Conference accomplishes nothing more than to make its scientific participants pause and consider their responsibilities in the great fraternity of human relationships, it will not have convened in vain.

It is impossible, of course, that anyone attempting to delineate such a wealth of diversified viewpoints could satisfy everyone in emphasis put upon respective trends of study and investigation in the broad field of mental health. There are undoubtedly those who feel that medicine has underestimated the contribution of psychology; there are those who feel that medicine has overestimated the contribution of the behavioristic sciences; and there are those who feel that psychiatry has not received its legitimate place in the scheme of things. In spite of these differences of opinion, however, there are certain aspects of this great sphere of child health concerning which we all ought to think and feel in unison.

Mental hygiene is an aspect of hygiene that takes a genetic interest in the behavior of an individual, dealing with assets and liabilities of life which may or may not develop into pathological behavior. It must concern itself with every factor contributing to the growth, development and personal welfare of a human being functioning as an integrated personality, and not as an organism functioning in segments of mind and body.

With these basic principles in mind it would seem only reasonable to suppose that the mental health of childhood belongs to no one group of society or branch of departmental knowledge, but that it should be the active concern and intelligent interest of doctor, teacher, parent, psychologist, social worker, psychiatrist, public health nurse, and every other constructive force of our social organization that comes in contact with the welfare of children. Is it ownership or leadership that we are aiming at in our competitive strivings? I presume pediatrician, psychologist and psychiatrist would answer "leadership." That being the case we must establish a basis for leadership by virtue of better production and less salesmanship. The pediatrician writing to this Subcommittee that "Psychiatrists have simply discovered a lot of things which doctors in general have known for a long time," is evidently unaware of the fact that the record of floundering in the treatment of nerves which the medical profession has established over a long period of years is nothing to boast of. In like manner the psychologist who claims that "mental hygiene lies predominantly in the field of education rather than in the field of psychiatry or medicine because education is the discipline set up by society to prepare individuals to meet the problems of life," seems unaware that the mental health of childhood and adolescence includes a far wider range of functioning than is now tabulated on the various academic pasteboards found in the files of school administration systems from kindergarten to graduate school.

From the behavioristic side of science one must frankly admit that we are confronted with a confusing amount of words and theories tending to proclaim some particular field of psychology and psychiatry as the one and only method of human salvation. Much of it is impractical and perfectionistic, smacking more of techniques and revelations than of an appreciation of the components of real life. The results expose us to the accusation of propagandists for a faith.

How can the psychologist and psychiatrist and pediatrician actually make good in the situation that confronts them? It seems to me that we can do so by a thoughtful consideration of what we have to offer the individual doctor, parent, teacher, social agency, not in words from Olympus but in constructive participation in our mutual problems. Leadership is the ability to serve well. The first requisite of serving well is an ability and willingness to study facts as they present themselves under all kinds of conditions unbiased by any hypothesis or point of view to which our lives may be dedicated. Childhood can suffer as much from specialized training without common sense, as it can from common sense without specialized training. The pediatrician who assumes a proprietary attitude toward the mental health of childhood without training in the educational, psychological and psychiatric aspects of child health is in danger of doing as little justice to facts as the psychologist who assumes similar prerogatives under the title of "clinical," and attempts to deal with matters for which he is insufficiently trained.

We need more centers where psychologist, pediatrician, psychiatrist and social worker can work together shoulder to shoulder collaborating in their respective contributions with the objective of creating opportunities to learn more and grow more. I have in mind such a center that began some dozen years ago to demonstrate the usefulness of what it had to offer to medical school, hospital organization, and community social service. Today its

pediatrics department has a full-time psychiatrist and psychiatric social worker attached to its staff, its obstetrical service has also collected funds for the establishment of a similar unit; the juvenile court in the community has acquired a full-time psychiatrist and a part-time pediatrician; and family case work, child placing, and public school system bring the child and adolescent clientele of this psychiatric out-patient service up to 55 per cent of its total registration every year.

Doctor Crothers has spoken of the necessity of training behavioristically intelligent, and socially minded physicians in our institutions of medical education. What we are giving medical students in this direction can certainly not be measured by the hours of psychiatric instruction advertised in catalogs of curriculum. There is need for a qualitative as well as a quantitative analysis of this material. There is on foot just now a definite movement among leaders of medicine and psychiatry to pool our resources of plastic and progressive standards in this sphere of departmental knowledge in the hope that the physician of the future with his background of medical school and hospital training may be better equipped not only to treat the total health of child and adult with a feeling of reasonable security, but able also to utilize and correlate a wealth of helpful contributions from allied fields of education which he needs to use in the intelligent practice of his profession.

BORDEN S. VEEDER, M.D.,

Professor of Clinical Pediatrics,

Washington University School of Medicine, St. Louis, Missouri

Doctor Crothers and his Committee have made a most interesting analysis and study of their subject. My place on the program, I take it, is to discuss the matter from the standpoint of the pediatrician, and I hope I may

be considered among those whom he terms "psychiatrically minded." My only claim to this distinction perhaps is that nearly ten years ago in a paper before the pediatric section of the American Medical Association I stressed the necessity of the pediatrician being interested in the mental development and illness of the child as well as in his physical problems and in more recent years I have had an active part in the development and management of the Child Guidance Clinic in St. Louis. The ideas expressed ten years ago were the result of a conviction that had gradually been reached by myself and a number of other pediatricians, and I am positive that this viewpoint has been gaining many adherents among this group.

In the tremendous growth of the child guidance, or mental hygiene movement for children, in the last decade, the pediatricians have been interested, but I must admit they have not as a group taken the place I feel they should have taken. Perhaps if the pediatricians had been more a part of the movement they could have pointed out to the psychiatrist and psychologist some of the pitfalls and difficulties they had gone through in the early days of the child health movement. The mental hygiene movement might have been slower and less spectacular but perhaps would have been more sound. Perhaps the situation that exists today where so much has been promised and relatively so little accomplished would have been avoided. At least less would have been promised.

The situation that exists today as shown by the report is most certainly not the fault of any one group, but rather the result of too rapid development, and the failure to think out thoroughly, and keep in mind, certain fundamental considerations.

The pediatrician and general practitioner group has been slow to widen its field, to look upon the child as a whole, to recognize that normal development implies the mental as well as the physical; to recognize that personality difficulties may make an individual as much of an

invalid as physical illness. This is in part the result of their training and it, I feel, comes from a distrust of the soundness of the mental hygiene movement and its propaganda. The pediatrician has passed through the "swaddling clothes" era of the child health movement from its physical standpoint, when all the ills of childhood were to be eliminated by such things as diet lists, baby shows, home visits by nurses, pamphlets on the care of the child, public lectures attended by those who flock to the "latest fad" and the establishment of clinics. The mental hygiene movement has not as yet emerged from this stage of development, but the present discussion of Doctor Crothers' Committee indicates this step is on the way. The problem is very similar, but is more complex from the number of interests involved, as has been pointed out in the report.

Further, I have a very definite feeling that the psychiatrist and psychologist have contributed somewhat to the pediatric attitude of suspicion, or skepticism. The psychiatrist above all other people with whom I come into close contact has a penchant for obfuscating his thought with a most perplexing, and I feel unnecessarily complicated, verbiage. I agree thoroughly with the layman's point of view, which Doctor Crothers quoted in his report.

The psychologists hold such controversial and opposed views that it is exceedingly difficult at times not to turn from them all in despair. The actions of some of the so-called "clinical psychologists" in practice, as those for example who give advice for a fee, over the telephone, on how to correct the child when he has a tantrum, or when he swears at or "cusses" his parents at the table, are probably more distasteful to the real psychologist than even to the pediatrician. One feels sorry at times for the sins that are committed in the name of child psychology.

But all this question of responsibility for the pediatricians' defects aside, I do not believe the situation is so

complex as one might gather from the report. It seems to me there are certain quite definite things which form a background and which can be agreed upon. If this is so the rest will logically develop, with proper experimentation, and eventually a sound program will evolve.

First of all, I do not believe that the physical and mental sides of a child's development can be shut off in separate compartments and can be handled as such.

Secondly, we must recognize that there are in a sense two distinct but related fields in the mental hygiene side. First, the guiding of the child into proper habits and the prevention of personality difficulties, and secondly, the correction or treatment of children who have for one reason or another developed distinct difficulties.

Third, that no form of group organization—and I most certainly resent the term "classical" being applied to any form of such organization at the present—can ever reach the vast majority of American children, any more than child hygiene or welfare clinics can do this work. Clinics have either a very definite experimental or scientific function, or else are necessary from socio-economic grounds. Groups may be necessary for the handling of certain complicated type of problems, just as it is necessary to send certain children to a hospital organization for proper treatment. Personally, I have reached the opinion that the child guidance group belongs to and should be a part of a children's hospital organization.

Fourth, any plan or program must be developed to meet the needs of all children and not restricted to those in large urban centers of population.

Coming down to a practical basis the only person I know who comes into close contact with young children and has the opportunity of seeing and foreseeing the concrete individual problem is the pediatrician and general practitioner. I can see no other way out but for him to take on the added function of forestalling abnormal men-

tal development and habits in the same way that he tries to prevent faulty physical development. This implies, of course, a knowledge of the essentials in this field. This is a matter of medical education where he should be given the proper "attitude" that the report stresses.

When the physician encounters difficult problems he should handle them in the same way he handles difficult medical or physical problems—by calling in the help of those who specialize and have superior training and experience. I cannot see the difference between this and any other field of practice. Let the psychiatrist have special technique just as the ophthalmologist or urologist has.

From the pediatrician's standpoint it seems to me that the solution will automatically take care of itself at exactly the same rate and to the same extent that the pediatrician conceives his field to center about the child and not about disease. Psychiatrists and psychologists, however, must clarify their own fields and controversies, and must realize that they must fit into the general scheme of things rather than take an outside, detached, and at times even a superior attitude.

We are all working in the same field and toward the same goal. We should not allow the field to be narrowed or the issue to be clouded over the question of domain, the fetish of organization, or by controversies over technique.

JOHN E. ANDERSON, PH.D.,

Director

Institute of Child Welfare, University of Minnesota

As a psychologist, I wish to express my approval of the report which Doctor Crothers has read. It seems to me that it is excellent and has very adequately and completely covered all the aspects of the problem and has presented us with a very concrete and real situation.

I would add only one point to the general discussion and that is to emphasize the fact that the situation which has developed and which is presented by him in all its complexity, is a situation which is a product of our modern time and cannot wholly or completely be ascribed to the effects of propaganda on the part of various organizations or individuals or interests.

The point I should like to make is that the parents of children, and the individuals who make up our modern society are faced by a series of complex problems which have not existed to anywhere near the same degree in previous periods, and which all of us together in various scientific and practical fields are attempting to attack and solve.

It is somewhat trite to point to the complexity of our modern civilization. I am interested only in emphasizing the fact from the point of view of the child, namely, that these complicated devices which are around us on every hand in our modern industrial civilization, our machinery, new modes of doing, transition from a horse-and-buggy age to an automobile age with all its complexity, are present in the life of the child from the moment he is born. They constitute from the standpoint of his own individual adjustment quite as great an array of problems to be solved by him, situations to be met, difficulties to be overcome, as are presented to groups of scientists who themselves are attacking the problem, or to the parents who are more directly responsible for the individual child.

I think this report represents a helpful approach to the whole problem. The complexity which is found in the report is a mirror of the complexity of the situation which faces all of us. I am sure the report represents a distinctly forward step, and that in the future there will be a much better integrated and more cooperative and effective attack upon the problems which the child faces.

ADOLPH MEYER, M.D., LL.D.,

Professor of Psychiatry,

Johns Hopkins University School of Medicine

The thought that has gone through my head while I have listened to this report has been how splendid it would be if we could limit the discussion to those who are actually working with the child; those who are seeing the problems offered and who know what one likes to put up to other sources for help; how these others are coming back and how they ultimately fit in the actual work with the child.

Some years ago the initiator of this Conference gave an opportunity for a personal discussion of this whole problem and I do not quite like to say the word which was one of the culminating impressions and perhaps resolutions, and yet it expresses something of the sense of bewilderment that confronted one as to how to approach a popularization of a consensus of opinion with regard to this question. The homely word was to "debunk." What does it mean?

We have heard that we psychiatrists use too much verbiage. I am afraid there is too much verbiage wherever one gets too far away from working with the child and limiting oneself to those things which have actually been studied with and on the child. If, for instance, instead of considering the salvation to come very largely from the angle of what has been dug out of or pumped into neurotics, I think it would be a good thing to eliminate from consideration a good many of the facts that are attributed to the child but have never been investigated in the child.

I should think in general our great opportunity has been the coming together and having to voice the verbiage so that we may go home—I don't want to say just what

I think—inoculated, let's call it, and immunized, glad that we are through the measles and the sickness of the verbiage, that we have a chance to go back and do something, and that we have become acquainted with each other and perhaps will save ourselves and the others from some of the verbiage.

DOUGLAS A. THOM, M.D.,

Director

Division for Mental Hygiene, Massachusetts Department of Mental Diseases

I feel that the difficulty among psychiatrists, psychologists and pediatricians resolves itself very much into the personalities that are involved in the operation that is being performed.

I daresay we should apply the same approach to our psychiatric problems as we do to any medical problem. We have to meet them on various levels. If a patient comes into a general hospital and has a crushed thumb we look after that thumb. We do not put that patient through a basal metabolism, or a Wassermann, or whatnot. We fix up the individual in a way that is medically satisfactory and we conserve as much time as possible and in general live up to a common sense plan of operation on a medical level.

The same thing is true, I think, in applying psychiatric technique to other problems, and in relation to psychologists and pediatricians. The pediatrician recognizes that there are certain problems which are confined to, or which concern the mental and physical welfare of, the child which he is perfectly capable of handling. He appreciates the fact that he has under him many students who are perhaps not getting the point of view that he desires them to have. He appreciates the necessity of enlarging their field of knowledge about the individual in general and it seems

to me we can leave most of these problems pretty safely in the hands of the various individuals who are directly concerned with them.

It is not a question of competing to see who gets the most trade, the psychologist or pediatrician or psychiatrist. It is a question of recognizing the particular field of inquiry which the specialized person can do best. As soon as pediatricians in general appreciate the fact that the child has to be treated as a living organism they are going to see that medical students in their particular branch are trained along their lines.

As soon as the psychiatrists can appreciate the fact that there is a physical aspect to the child's life, we are going to have psychiatrists who are better trained in the field of pediatrics. We are going to appreciate the fact that the psychologist has a tremendous amount to contribute in the field of adjusting the child, of overcoming difficulties that neither the pediatrician nor psychiatrist can offer.

Frequently we see in practice the child reacting to some unpleasant school experience to which there is attached considerable emotion with such physical symptoms as neurotic vomiting, headaches, and other symptoms of a similar nature. The question always arises as to whether we are dealing with a definite physical problem or whether these symptoms represent an unconscious effort on the part of the organism to avoid a difficult situation, which may be brought about by many different factors—poor intellectual equipment, special disability, or feelings of inadequacy which make it hard for the individual to fit into the particular situation which he has to face.

In an effort to solve these problems, it is ofttimes necessary to turn to the pediatrician or the psychologist for assistance. The more complicated and involved problems must necessarily be solved by the cooperative effort of all the varied groups that are interested in the growth and development of the child, and these various groups

must keep in mind that the effort is one of cooperation and not of competition.

Certainly, I have to turn to pediatricians, to psychologists. I expect my psychologists to have training and have suggestions, to have therapeutic methods of treating cases that I have not got. I expect that every case that I see, if I cannot handle the thing from the medical point of view, is to be referred to the pediatrician. There is so relatively little trouble in meeting these problems if the individuals, and if the professional groups, are not suffering from mental indigestion themselves.

GOODWIN B. WATSON, PH.D.,

Assistant Professor of Education

Teachers College, Columbia University

I am one of the dangerous persons responsible for training psychologists to carry a broader function than most of them have been trained to carry at the present time.

Two or three points of development that the Subcommittee report seemed to me to lead toward were not completed. I should like to raise them for exploration, at any rate.

It seemed to me that one of the basic reasons for the desire to hedge about this particular field of work with requirements for proper training is an unconscious or half-conscious recognition on the part of all of us that we do not know as much as we pretend to. If one who has had ten years of medical training and experience finds himself, in dealing with a child, puzzled by the case and uncertain as to what really effects a cure, it is apparent that anyone with less training would be more puzzled.

Similarly, it seems that if, after ten or twelve years of educational psychological experience, we in our clinic are

confronted with cases that baffle us, a physician who has spent only a year or two of brushing up on educational psychology is going to be quite unqualified to deal with the situation.

That dissatisfaction which all of us have with our own competency seems to me to lead to a good deal of suspicion which we project upon other people, particularly upon people who have had a different kind of training. The conclusion is that there is need of a more thorough, complete training.

The Subcommittee indeed pointed toward that but neglected, it seems to me, one fact in the history of education that is exceedingly important. That is whenever anything in addition has been suggested for training, professional or otherwise, it has always been added on to everything that was there before, and presently the load becomes such that economic forces will not sustain it. You just cannot put a person through all the social case work he ought to have, and all the medicine, and psychology, and all the education he ought to have to do this job if you are going to retain in all those disciplines all the material that has accumulated there during the generations that have passed.

We are faced with the need to analyze the situation to determine much more definitely than we now know what training is necessary to fit one to deal with the mental and personal development of children, to find out what techniques produce results, then cut down the training time, eliminating those things which, though good, are not good enough to justify the time they require.

I see no possible hope for training adequate personnel if we assume they must know everything the doctor has been supposed to know, and everything the psychologist, the educator, and social case worker have been supposed to know. The conclusion toward which the Subcommittee report seems to point in a constructive fashion is a reanalysis of those materials of training, a selection of

the crucial and significant parts as rapidly as they can be determined, and the reconstruction of curricula.

J. V. GREENBAUM, M.D.,

Associate Professor of Pediatrics

University of Cincinnati, College of Medicine

I am drawing upon my own personal experience to illustrate the progress of medical education. Twenty years ago in my education there was no recognition that the child had a personality. About ten years ago the psychologists came upon the scene and changed this impression. They made a contribution for which we owe them a debt of gratitude. Without their tests certain very important institutions, with one of which I happen to be connected, would not have been established. It was the vogue at that time to make a mental test on children and send them to institutions if the intelligence quotient was not up to a certain number.

Certain serious mistakes occurred in our city as well as other places, and as a result the doctors took an active stand in order to prevent this difficulty from recurring. In certain institutions we have made some very important discoveries. We have found out that the trouble lies either within the child himself or in the environment about the child, or in a combination of both factors. These discoveries we have presented to the students in our school. We have tried to show them that every behavior difficulty is a medical problem.

Judging from certain experiences that I have had since I have been teaching I think we have succeeded.

I want to express my appreciation to Doctor Crothers for this contribution, and I am sure the medical schools of the country need exactly the point of view which has been presented by this Subcommittee.

PAUL EDWARD KUBITCHEK, M.D.,
Child Guidance Clinic, St. Louis, Missouri

After a few years of experience in dealing with behavior problems of children, I have come to some rather interesting conclusions as to what we need in the field of child guidance.

Speaking from the viewpoint of a psychiatrist rather than of the pediatrician, but also with an impression of what the pediatrician needs (because we have had, I think, probably a closer relationship with pediatricians than in many of the other clinics in the country), I think there is no doubt about the need on the part of the public for information concerning the proper method of dealing with the child's development and education, his personality development.

The avalanche of popularized literature on psychology, psychiatry, mental hygiene and child welfare has left many an intelligent parent with mental indigestion, and in a state of confusion as to what they should do. I think the existence of that state is evidence that the medical profession has failed to give to these people the information they have wanted and they have turned because of that to other sources. I think the pediatrician wants the information that will enable him to meet that part of his problem. I think the child guidance clinics and the so-called classical units have established something of value.

I believe that much needs to be done in the correlation of the work between units of that type and the medical center. I think psychiatrists should go back to the medical schools, back to medicine. I think the isolation of psychiatry from medicine is a most unfortunate thing.

I am heartily in sympathy, of course, with the establishment and maintenance of such units working in the community together with social agencies, the courts, the school systems, but I think that is attacking the problem

from the outside. The surface does need to be dealt with. It is the only way, I think, that it can be dealt with at the present time. Therefore it should be continued, but I think the greater emphasis should be placed on attacking the problem from the inside, working out a practical, usable type of elementary psychology and psychiatry that is adaptable to the use of a medical man, particularly the pediatrician. I believe that could probably best be worked out by the hearty cooperation and correlation of work between the pediatric centers, the children's hospitals and units of psychiatrists, psychologists and medical workers.

APPENDIX

Methods of Obtaining Information

The report of this Subcommittee is not a scientific document reporting statistical data. The Subcommittee started off with the conviction that doctors in general could occupy a position of dignity and power in any program for adequate supervision of so-called mental hygiene in childhood. We believe that relatively few doctors were thoroughly aware of the activities of allied groups who were doing pioneer work in the general field of psychiatry and psychology. We felt sure that a frank discussion of the whole confused situation might be useful in promoting a better understanding between general practitioners and pediatricians on the one hand, and psychologists and psychiatrists on the other.

Our method, aside from conferences, was that of correspondence with selected individuals upon selected topics. If we felt that agreement or challenge would bring out a reply which would clarify a point we had no hesitation in making our letter conciliatory or provocative. We did, however, send exactly the same letter to each group.

I. Twenty-five pediatricians received the following letter:

I hate to bother you with another questionnaire of which too many are going around at present, but it seems very important to find out certain things about so-called psychiatry and psychology in childhood, and I wish you would try to formulate a definite answer to each of the following questions for the use of our committee.

1. Is psychiatry an attitude or a technique? This question really involves a decision as to whether or not doctors without technical

psychiatric or psychological training are justified in studying human nature and particularly whether they are justified in trying to handle any of the problems that are generally regarded as mental in origin, for example, habit breaking, discussion of educational problems, and so on.

2. Should psychiatry be employed by the first or last person who sees the child? That is, should the pediatrician refer every child with apparent mental difficulty to a specialist, and incidentally is a specialist for that purpose available to you and trusted by you?

3. How far do you feel that the general pediatrician is either willing or able to go in dealing with psychiatric problems? It seems to me quite obvious that particular pediatricians have gone very far and very efficiently into this problem, while others are unwilling to touch it.

If you have any definite impression on this matter, it would be of the greatest value, as one of the main difficulties that the Committee faces in trying to make a plan is absence of information as to what is being done at present. If you have any particular book or technique or any other method that you are using effectively and frequently, I should be delighted to hear about it.

II. Twenty-five psychiatrists received the following letter:

The formulas which are supposed to rule the Conference are

What is being done?
What should be done?
How to do it?

I have conscientiously looked at these questions in regard to the question of psychiatry and it seems to me entirely clear that our particular Committee not only cannot but need not try to find out the answers.

If we can possibly clarify the question of "who shall do it?" I shall be content. The chaos at present seems to me to be due to the fact that many propagandists are spreading abroad articles, which may intrigue a number of people, but which can hardly instruct the ordinary mortal.

I should like to see whether the members of this Committee can agree on a few points:

1. Is the subject known as "mental hygiene," as far as it concerns children, predominantly in the field of education in general, of psychology in a relatively narrow sense, or of medicine in general under the leadership of psychiatrists?

2. If it is impossible to answer the first question is it possible to suggest proper fields of interest to these or other groups and to suggest bodies of knowledge appropriate to each? A fairly definite answer to questions 1 or 2 seems to me necessary before discussing—

3. What type of premedical training could be advised in order to establish medical attitudes of a useful sort?

4. Without attempting to define an adequate course in psychiatry, how much time should be allocated in order to give an adequate orientation in this subject?

5. Granting that we can agree upon a desirable type of medical graduate, how shall he be advised on graduation? At this point, it seems clear that we are going to be forced to define a number of things. For example, it seems to me that we ought to be able to point out the validity of experience and curiosity, and the distance to which they are safe guides without advanced technical psychological or psychiatric training. Then it would be useful to try to point out special methods of various sorts with suggestions for testing their validity. The value of accurate mental measurements and so on will have to be considered. The safety of application of methods on the basis of partial knowledge, psychoanalytical procedures for example, needs consideration.

Dr. Anderson raises a question of fundamental importance when he insists that anyone who hopes to be a good psychologist should be familiar with the scientific data already in existence. This involves a duty which we ought to undertake. Can we point to a manageable body of accepted data for study or even suggest a definite field? I am sure that such data are available in Dr. Anderson's field and it is possible that they can be studied to advantage by others than technically trained psychologists. I am eager to find a comparable accepted body of fact in the psychiatric field, and its discovery and description seems to me one of the major opportunities of this Committee.

6. If we can agree on a plan which keeps the general control of "mental hygiene" in medical hands, what relation should the interested, but not specialized doctor, maintain with the various people trained as technical assistants to psychiatrists? Can we in

any way clarify the fields of activity of such people as "clinical psychologists," "psychiatric social workers" and so on?

It is, of course, clear enough that this Committee can drift almost anywhere, but I think that if we struggle primarily with the question of training and distribution of personnel we may arrive within sight of land.

III. Ten psychologists received the following letters. The enclosures referred to came from letters received from members of the first two groups:

As we all know a tremendous literature on child guidance has grown up. The various committees of the White House Conference are considering the problem from all sorts of angles.

The particular Subcommittee of which I am a member is trying to discover means of clarifying the situation as far as practitioners of medicine are concerned. We realize that pediatricians, by and large, are doing a good deal of advising upon mental problems. Two letters which state, rather brutally, the attitude of (1) an intelligent pediatrician who has made valid contributions in the physical field, and (2) a director of a formal clinic are enclosed.

The weight of opinion from doctors, I should say, is in favor of regarding child guidance as a part of medicine. This attitude seems to me entirely sound only if the relation between "mental disease" and "mental health" is very clearly defined. I am not at all clear that the conviction that child guidance is an exclusively medical specialty is well founded. Is it possible to state in a relatively brief way the arguments, which must be in existence, in favor of regarding child guidance as a part of education? Could you define in any helpful way the limitations which you would like to set up in regard to (1) psychology (2) psychiatry (3) pediatrics? Or, if you choose, would you defend a statement that doctors should take a subordinate place except where structural changes or definite disease exists?

I realize that all this involves questions that cannot be answered briefly. If you know of any volume or paper which is relevant and authoritative, I should be glad to know of it.

I am sure that you realize the present chaos and the underlying ambitions of various groups which make the problem more

chaotic. Anything that helps us see difficulties or suggests solutions will illuminate, or possibly simplify, our problem.

With this letter went the following covering letter from Doctor Anderson:

I am enclosing herewith a letter which was sent to me by Dr. Bronson Crothers of the Harvard Medical School, who is chairman of the Subcommittee on Psychology and Psychiatry of the Committee on Medical Care for Children, of the White House Conference with a request that I forward it to a number of psychologists who would be willing to state their attitude quite frankly on the questions which are raised in his letter.

Dr. Crothers wishes me to add a statement of my own attitude in addition to the statements which he encloses. The following quotation from a previous letter of mine to him expresses my feeling:

Mental hygiene lies predominantly in the field of education rather than in the field of either psychology or medicine since the primary purpose of education is to prepare individuals to meet the problems of life. While education should receive all the assistance it can from psychology and psychiatry, nevertheless it is the discipline which has been set up by society for the training of individuals and which has both the prestige and historical background for work in this field. It does not seem to me that society can or will establish a separate discipline independent of the schools for the training of the general run of individuals. Psychiatry will, however, continue to deal with abnormal individuals. Probably I do not know what is meant by "mental hygiene" for normal people if by that term a field distinct from education is meant.

The control of mental hygiene is not now in medical hands nor will it ever be. It is true that there is a particular group of physicians that are emphasizing certain principles of medical hygiene. If, however, an individual steps outside of this particular group and acquaints himself with what is happening in society, he will immediately see that there are great groups outside the medical field that are engaged in the formulation and presentation of doctrines in the mental field. One needs only to mention groups such as the Christian Scientists and the various psycho-therapeutic cults; moreover, every religion contains many elements of mental hygiene. To say that physicians are to assume complete control of

the mental hygiene field is to say that physicians are going to control society. It seems to me that the interests of the physician in the field should be scientific rather than propagandistic and that his purpose should be to establish principles rather than to embark on a general mission for the propagation of faith.

I will appreciate whatever consideration you are willing to give Dr. Crothers' request.

(Signed) John E. Anderson

IV. Ten neurologists received the following letter:

The Subcommittee on Psychology and Psychiatry is trying to find out whether there is any clear and generally accepted attitude toward the general subject of "mental hygiene" which can be used as a basis of a report.

We have asked a number of psychiatrists and find a fairly uniform feeling that special psychiatric training forms the most effective background.

Pediatricians are far less well-informed and are pretty vague about the whole matter, but a few are sure that the field of mental health falls into their specialty.

A few psychologists are equally certain that "mental hygiene" is essentially a part of education.

In order to round out our data would you be willing to consider the status of the trained neurologist in this matter? The following questions are the ones which suggest themselves to me:

1. Does the neurologist see any considerable number of so-called "behavior problems" in children? I do not, of course, include mental defectives or epileptics.
2. When such cases turn up is the special technique of neurology particularly useful or are the attitudes developed by neurological practice of great importance?
3. Does it seem to you likely that "child guidance" will become or should become a rather distinct sub-specialty of medicine, or can most of the problems be handled by the medical profession as at present organized?

Of course, these questions are mere suggestions and I should welcome any discussion you feel like adding.

As other groups were suggested, individual letters were sent. For instance, the status of psychiatric social workers was the subject of a correspondence which is given in full later (page 125).

All answers were given to each member of the Subcommittee. Attempts to prove by any mathematical procedure that a given percentage of each group agree at any given point are futile. The method is valid, however, in one way. A group, with some initial familiarity with the field, has accumulated and reviewed frank expressions of opinion upon certain obviously controversial points. With this added information, it has reconsidered the whole subject and agreed upon its report. We can report that we have managed to preserve our original point of view, practically undamaged. At times, we were quite aware that resolute optimism and a selective blindness to certain arguments were the only things that kept us from changing our minds. However, having brought our original ideas through rather dangerous argumentative waters, we present them with some confidence. The position of the general practitioner seems to us so strong and the claims of others so confused that we are willing to throw what intellectual and emotional reinforcement we can toward the doctor of medicine. If he is wise, however, he will recognize the ability, the resourcefulness and the tenacity of those who are conducting the friendly but resolute siege. We are sure that the correspondence warrants the conclusion that the general practitioner *can* hold a position of dignity and power, but we do not feel that the position is impregnable.

Typical Groups—Primarily Educational

THE MERRILL-PALMER SCHOOL

This school is carrying on one of the recognized experiments in education. It will be noted that psychiatry is not regarded as dominant. Furthermore, parental education is not conducted by specifically trained social workers. The school is very cheerfully withstanding various criticisms. First, it is quite clear that "child guidance" is thought of in educational terms; second, psychiatrists in general do not accept the limitations for their specialty suggested in

the sentence, "Whenever there is a reasonable suspicion that the case under question is a post-encephalitis, and epilepsy, a pre-dementia praecox, runs clear cycles, has chorea, and so forth through the list of usual psychopathological conditions, the case is referred to or taken into consultation with psychiatrists or neurologists."

A different objection is made by certain leaders in the nursery school group who feel that children are regarded as experimental material and are subjected to excessive observation.

No one who has seen this school would maintain that a serious and responsible educational procedure is not being carried out with effective, though perhaps unorthodox, cooperation from doctors.

Letter from Merrill-Palmer School, Detroit.

We have been somewhat tardy in replying to your letter which came, as we wrote you, just at vacation time. I did feel, however, that it was desirable to have the group consider the questions carefully in order to give you as intelligent a reply as possible.

We probably have been unusually fortunate in our relations with the psychiatrists here but in general I think there has been little disposition on their part to feel that we were encroaching in any way because we have received such excellent cooperation from them.

I enclose the reply as it has been worked out by the group and we shall be glad to amplify it for you in any way you wish.

The Merrill-Palmer Motherhood and Home Training School was founded in October 1918, as the result of the will of Mrs. Lizzie Merrill Palmer made in May 1916. The property which was left, appraised at $3,000,000 when left but since much increased in value, was intended for use in establishing a school in which "girls and young women of the age of ten years or more shall be educated, trained, developed, and disciplined with special reference to fitting them mentally, morally, physically and religiously for the discharge of the functions and service of wifehood and motherhood, and the management, supervision, direction and inspiration of homes."

The school began to function in February 1920, with the appointment of Miss Edna White as its director. Nutrition and health work with public health nurses, continuation school groups, and with groups of foreign women was developed immediately. Programs in psychology and education followed within a year. The annual report of the school for 1921 points out that: "One of the most vital and pressing problems confronting agencies engaged in homemaking education is that of developing better methods of training in child care and child management. But children will not be available for observation in developing such methods unless a situation can be created which furnishes unquestioned advantages to the children themselves, as well as possibilities of training for the college or high school student working on the problem. . . . The nursery schools of England, established under the Fisher Act, have made the best attempt at organized education for young children up to the present time."

A trip to England in 1921 convinced Miss White that schools of this type could be made of vital value to young children and at the same time could be used as training schools for young women. The report continues: "We feel that the plan (of establishing a nursery school) offers not merely a real opportunity for physical, mental, and social development, but also an opportunity to a group of young women for a vital type of laboratory work in child psychology, child health and nutrition. Training in the sociological problems immediately related to the family, and in field work connected with social agencies devoted to children's problems is also part of the plan."

In January 1922, the nursery school was opened, and a group of senior students from Michigan Agricultural College began resident work at the Merrill-Palmer School where courses were offered in Child Psychology and Child Management with laboratory in the nursery school, in Child Nutrition with laboratory in the children's diet kitchen, in Social Work as applied to children, and in Household Management.

Since that time the residence teaching program has developed to accommodate the demands made upon it by the numerous senior and graduate students who are sent to the school by grade A universities and colleges all over the United States or who register as independent students from all parts of the United States and from several foreign countries. The courses given are of two

types: (1) Orientation courses for the training of those who are training directly for wifehood and motherhood, and (2) Courses for advanced professional training to meet the needs of students preparing for the special fields of (a) physical growth and development of young children; (b) mental growth and development of young children; (c) nursery school teaching; (d) parent education.

Not only does the program train students who expect to become home makers and parents or professional workers, but it also includes work for persons (both men and women) who are already parents and for the further training of persons (doctors, nurses, social workers, teachers, and so forth) who are already engaged in professional work. It includes also programs in extension with public, elementary and high school as well as parochial school groups, cooperation with social agencies including hospital and public health clinics, church parent, and foreign groups, etc.

In 1924, after consultation with a number of psychiatrists and pediatricians, a Consultation Center was established in order to demonstrate to the community work in child guidance. This center functioned with two psychologists, a nutritionist, a parental education specialist, and a consulting pediatrist. Cases found to involve psychotic tendencies were referred to practicing psychiatrists. As centers for similar work developed throughout the city increasing numbers of cases were referred to these centers until, in the fall of 1927, it was felt that the community had established sufficient services to make possible the discontinuance of the Merrill-Palmer demonstration center. Individual members of the Merrill-Palmer staff still function, however, as members of some of the community clinic centers.

An important place in the program of the Merrill-Palmer School has always been occupied by research in physical growth and development (including dental and orthopedic work), in mental growth and development, in education both of children and of adults, and in nutrition. Since 1922 many books and articles have been published from the school, many being given to reports of findings resulting from research conducted by the school staff.

People who are thinking about education today are generally agreed that the essential function of education is constructive building toward optimal health (both mental and physical) and toward optimal effectiveness (vocational, cultural and social), and that it is concerned only incidentally with correction of defects or

prevention of pathological conditions, the program for which belongs to medicine, psychopathology, social work, and related fields. This is especially true of parent education, a branch of education which concerns itself with the building of optimal home and family life, especially as home and family contribute to the development of children. The parent education program is vastly broader than correction or prevention; it gives its major emphasis to the guidance of healthy, normal families, the essential aspect of which is not pathology but normality.

We feel, therefore, that parent education programs should not be in charge of persons who have specialized in pathology and disease, but should rather be supervised by persons who have specialized in an understanding of normal family life and of the growth and development of normal healthy children. A qualification is necessary, however, since it is our experience that in spite of the ideal which parent education holds for itself necessity for dealing with pathological or markedly a typical family situation or personalities often arises. Knowing this, we feel that the educator or psychologist who conducts parent education programs should have available physicians, psychiatrists, and other specialists in pathology to whom such cases may be referred and should be trained to know when such referring of cases is advisable.

There are other reasons why a parent education program should be in charge of educators especially trained for the work rather than in charge of specialists in pathology. One of these reasons, perhaps less important than others but nevertheless a factor to be considered, is that parents are inclined to be frightened by situations or by physical or personality traits which are not at all pathological. This bewilderment or fright may inject into the family atmosphere a tension which defeats the very end parent education has set out to achieve. An additional reason is that parent education as a program proceeds on a teaching basis and requires skill in teaching techniques. Few specialists in pathology are prepared also as specialists in teaching, whereas the educator has been trained especially as a teacher.

We cannot answer the third question. There are such complicated interrelationships between various aspects of the school program and the functions of the staff are so varied, it seems next to impossible to allocate costs.

We have found in our experience that it is quite easy to draw

the line between cases which are regarded as educational problems and those which are to be regarded as psychiatric or medical problems. Perhaps the reason there has been little confusion about it and the reason we draw the line in approximately the same place as do the psychiatrists and physicians with whom we work is that we sit in frequent conference together with these psychiatrists and physicians and work in the closest possible cooperation with them.

Whenever there is a reasonable suspicion that the case under question is a post-encephalitis, and epilepsy, a pre-dementia precox, runs clear cycles, has chorea, and so forth throughout the list of usual psychopathological conditions, the case is referred to or taken into consultation with psychiatrists or neurologists. When, on the other hand, the case seems simply one of school or family adjustment, of clearing up relationships between teacher and patient, playmates and patient, parents and patient, parent and parent, and so forth; or when it seems one of establishing desirable attitudes toward home and school or toward work, play, routine, and so forth; or when it seems one of simple habit training or of school guidance, of group adjustment, and so forth the psychiatrist refers the case or takes it into consultation with the psychologist or the parent educator. All mental and educational tests are given by educators or psychometricians. We have always been rigorously certain that physical complications are checked upon before seeing any case and that the case is referred to a physician whenever there is the slightest suspicion that physical complications have arisen during the course of contact with the case.

CLINICS WITH DEFINITE RELATION TO COURTS

The work of such clinics as the Judge Baker Foundation in Boston, and the Institute for Juvenile Research in Chicago are fully considered in connection with the Subcommittee on Delinquency (IV C 2) but a few questions seemed to us relevant, particularly in relation to cases in families with some means where delinquency may be found which has not led to arrest. Such cases are likely to be discussed with the regular medical adviser.

INSTITUTE FOR CHILD GUIDANCE [1]

I. INTRODUCTION

In June, 1926, the following summary of the purposes of the Institute was published:

The Commonwealth Fund has announced the establishment, on July 1, 1927, of an "Institute for Child Guidance" of which Lawson G. Lowrey, M.D., will be Director. The chief purposes of the Institute, which is the outgrowth of the experience gained in the operation of the Fund's five-year program in the field of prevention of juvenile delinquency, will be four:

1. To make possible further study and research in the field of mental hygiene for children, with special reference to the causes and methods of treatment of behavior problems.
2. To provide facilities for the training of psychiatrists and graduate psychologists in practical child guidance work, Annual fellowships for this purpose will be offered through the National Committee for Mental Hygiene, with which the Institute will be affiliated.
3. To provide field training in child guidance for students in psychiatric social work at the New York School of Social Work and the Smith College School for Social Work. Both of these institutions will be affiliated with the Institute and will offer a number of fellowships in psychiatric social work provided by the Fund.
4. To offer adequate clinical facilities for the thorough study and treatment of children presenting problems in behavior and mental hygiene. Cases will be accepted from parents, schools and from various cooperating agencies.

II. EVOLUTION OF THE IDEA

It may be of interest to analyze somewhat further the fundamental considerations which led to this step.

The Former Program

The Commonwealth Fund inaugurated its original five-year program in the field of mental hygiene in 1922. It was undertaken for a variety of reasons. Among these were "the wide em-

[1] Report of the Director of the Institute for Child Guidance to the Administrative Board, for the year ending June 30, 1928. New York. *Reprinted by permission.*

ployment of unintelligent methods of dealing with delinquents and criminals, the persistence of the punishment theory, the fact that a very large proportion of criminals begin their unsocial careers in youth and that many children are impelled toward delinquent conduct through lack of wisdom and understanding on the part of parents, teachers and others—all these things pointed to the outstanding need for a better comprehension of the entire situation, for the placing of emphasis upon the checking of wayward tendencies early in their development, and more concretely, for the development of methods and processes by which results of this character might be secured . . . the Fund did not expect to cover the field in any comprehensive way, but rather to test certain new methods from which results of a preventive character might be anticipated, to establish public knowledge of such methods if they proved sound, and to assist in increasing the number of social workers trained for work in this field." [1]

Predecessors

The Institute is a logical evolution to meet the needs discovered by two divisions of this program—the Bureau of Children's Guidance of the New York School of Social Work and the Demonstration Child Guidance Clinics operated by the National Committee for Mental Hygiene.

The basis of the efforts of these divisions was the application of psychiatric technique and knowledge of the underlying factors of human behavior to the problems of delinquency and problems of conduct not grave enough in social implications to be classed as delinquency. They were operated with complete units for doing psychiatric, psychological, and social work with individual patients, and represented models upon which the development of the Institute was based. Accordingly some discussion of their activities and the conclusions to be derived therefrom becomes necessary to understand the fundamental principles that underlie this organization.

The Bureau

The Bureau of Children's Guidance was established as an integral part of the New York School of Social Work for the major purposes of providing for the study and treatment of behavior problems in children and for field training in mental

[1] Commonwealth Fund Annual Report, 1923.

hygiene for students in the New York School, particularly for the group who were going into psychiatric social work and into visiting teaching. From the beginning its aim and ideal was to do an intensive type of training, handling a small case load, studying every case with great thoroughness and not attempting to meet in any way the needs of the community. Certain stable sources from which cases could be referred were established and maintained. The Bureau was an outstanding success in training and research, the latter in the sense of the evolution of new concepts with respect to the causes and treatment of disorders of behavior. Its success in these two fields, together with the new vistas to be investigated which it opened, played an important part in the evolution of the plans for the Institute.

Demonstration Clinics

The Division on the Prevention of Delinquency of the National Committee for Mental Hygiene was charged with demonstrating the part that psychiatry could play in the actual understanding and treatment of delinquents. Accordingly psychiatric units, consisting of psychiatrist, psychologist, psychiatric social worker, and clinic manager were sent, on request, to cities in position to utilize such services and make some provision for their continuance beyond the period of the demonstration. These *clinical* demonstrations had definite community responsibilities. Needless to say, five years of activity produced a considerable evolution in the philosophy underlying the child guidance clinic's treatment of individual problems in behavior and in the relationships of the clinic to the community and its organized social institutions. Several points in this evolution and some of the results of the program as a whole have proved extremely important in determining the present organization and working methods of the Institute.

Important Conclusions from the Program

1. It became quite clear that the treatment and prevention of behavior problems is a matter in which the community as a whole has a considerable interest and responsibility, even if this be only in protection of the community.

2. It was also clear that no single clinical organization could hope to study and treat all the cases of behavior difficulties that a community might present, because of the involved and arduous nature of the work.

3. This led to the conclusion that the clinic should be a coordinating, cooperating center for work with institutions and agencies already in the community and that it should not be organized to duplicate existing services, such as child placing or family case work. Its primary function should be clinical work with mental hygiene problems, interchanging services with other organizations as the need might require.

4. As community clinics followed the demonstrations and other cities became interested and set out to establish clinics on their own responsibility, the dearth of fully trained personnel became increasingly obvious. Improvement in clinical methods and practice and the new emphases developed made it essential that any individuals entering actively into this field should have a period of special training and experience in the technical division of the clinic to which they belonged.

5. Perhaps the outstanding feature of the child guidance clinic method of work is the combined attack made upon the problems presented, through the joint efforts of psychiatrist, psychologist, and psychiatric social worker, as well as other individuals and organizations which it may be necessary to mobilize in the treatment of a given problem. Experience led to an increasing emphasis on social-psychiatric treatment as opposed to psychiatric treatment only (direct psychotherapy of the patient) or social treatment alone (by altering the environment only). Thus all factors in the situation, personal and environmental, were to be brought under treatment in the attempt to secure personal and social adjustment or readjustment.

This is inevitable when it is recalled that behavior, whether normal or abnormal, healthy or unhealthy, socially acceptable or unacceptable, is determined by a complex interaction between the individual and the environment, each modifying and reacting to the other. In many instances there are abnormal individuals in an environment which provides a normal series of stimuli. When this occurs, disturbances in behavior are to be expected. In a larger number of cases the individual is, so far as general standards of judgment may be applied, essentially normal, but has a series of abnormal stimuli from the environment and so behavior problems are created. In a small proportion of cases there are outstanding abnormalities both in the individual and in the environment.

6. All the experience of the demonstrations indicated the need for the very highest degree of technical skill in gathering and interpreting the factual material derived from the several fields of study, not only in work with individuals, but also in utilizing this material for educational effort with parents and others in the community, and with professional workers who deal with people and their problems. Technical skill alone was apparently not enough. So many of the problems to be worked with are common to the everyday life of most people that they tend to be outside the usual range of professional activities. Integrating the work with that of other organizations in the community, developing in it an alertness to mental hygiene and behavior problems and the significance of more rational methods of treatment—all these became and still remain an integral part of the operations of a child guidance clinic.[1]

7. Interest in children's problems has become general and apparently at no time has the child and his behavior been subjected to a more widespread study or a greater attempt at rational understanding than is now manifest.

8. Mental hygiene technique as applied to the ordinary problems of social case work has become of increasing importance to all social workers. The result is a markedly increased alertness to the mental hygiene implications of many types of problems concerning which there was little understanding a decade ago. Its contribution to this development is by no means the least achievement of the Fund's five-year program. The kinds of work for which demand is being made, as well as the communities interested, have increased greatly.

9. A practical point in evolution was an increase in demand for personnel as larger and more complex cities were supplied with demonstration teams, and more and more communities established clinics. The training work of the demonstration clinics (never very great) of other organizations, and that of the Bureau was not sufficient to supply the demand.

Review

Therefore, in reviewing the whole situation, the Fund officials decided that it was desirable to establish a *field work training center*

[1] For some further elaboration on this subject see *Commonwealth Fund Annual Report, 1924,* pages 27, 28, 29.

which would provide comprehensively for the training of social workers from both the New York and the Smith College Schools of Social Work, as well as for psychiatrists and psychologists. New York City seemed the logical place to locate this enterprise. Accordingly, plans were drawn up for an independent organization with its own Administrative Board and a separate staff. While the organization was to be and is independent of the New York and Smith Schools, provision was made for close integration with their work by having the directors members of the Administrative Board, as is the director of the National Committee for Mental Hygiene, in the interests of the training of psychiatrists and psychologists.

Preliminary Steps

It was necessary to incorporate the organization and secure a license for the operation of a dispensary in accordance with the laws of New York. This was duly accomplished in February 1927, under the membership corporation law which provides for the operation of non-profit making corporations.

Staff Selection

The staff for this very complex, difficult, and, in many respects, unique piece of work was carefully chosen on the basis of actual experience in the field of child guidance. An attempt was made to secure people with diverse training, representing as many points of view as were known to exist. The quarters now occupied were secured and rooms built to accommodate the staff and student group. Furniture and equipment were purchased and the Institute duly opened as announced, on July 1, 1927, with all major items of furniture and equipment and the majority of the staff members on hand. One hundred and forty-eight active cases were received by transfer from the Bureau of Children's Guidance, which ceased operations on June 30, 1927. The first fellows in psychiatry and psychology reported in September, the Smith College student group the first week in September, and the first large group of New York School students at the opening of the fall quarter in October (although two students from the New York School had carried on field work in which they were already engaged during the summer quarter).

This Report

The purpose of this report is to set forth in some detail the ideas and ideals under which the Institute has been operated. An attempt is made to evaluate as well as may be done the accomplishments of this first year. Needless to say, the problems of organization and of establishing the clinical work of the Institute have required a large amount of time and attention. It is, however, fair to say that most of these issues have been settled and that the Institute at the beginning of its second year has become well stabilized.

III. THE INSTITUTE PLAN

Training Problems

The Institute was requested to provide training for five fellows in psychiatry, three fellows in psychology, thirty-six students in any quarter from the New York School, and twenty students from the Smith College School for their nine months of field work. It was obvious, however, that during the first year it would hardly be possible to provide adequately for so large a group of students in social service. Accordingly, in conference with the directors of the two Schools an agreement was reached by which Smith College was to have eight places for the first winter, the New York School sixteen places for the first quarter and up to twenty-four for the second and succeeding quarters. It seemed also desirable to have the fellows report for duty at varied times throughout the year in order that some overlapping might be possible.

The number of people to be trained became the major issue in determining the size of the staff and the provision for certain types of services which would not be strictly necessary in an organization doing case work only. Since the Institute is a center for *field or clinical training* in the practical matters of the study and treatment of children presenting behavior and personality problems, it is not, in any usual sense of the term, a place for theoretical or academic instruction. It has, accordingly, no courses as these are defined in universities. For the most part its training is done through carefully supervised intensive work of students with individual patients.

Points of View of the Staff

Certain needs stand out for such a program. Perhaps the most important of these is that the staff should be dominated by the point of view that all cases are to be approached not as routine problems in study and treatment but as being likely to yield new light. The least charted field is that of treatment. Enough is now accurately known concerning the causes of behavior difficulties in children to constitute an adequate foundation for their study and understanding. In the intricate field of treatment fewer accurate principles have been established and individual clinics use what are superficially quite different methods and yet achieve approximately the same results. It is, therefore, particularly desirable to approach the treatment of a case with the attitude of comparing various possible methods so that the principles underlying satisfactory treatment may eventually be evolved. This is especially important at the present time because of the widespread interest in this type of work and the many angles from which it is being approached, some of them basically unsound or inadequate. There must go with this attitude a full feeling of the responsibility, which the Institute has, to give to its patients the very best treatment that it can, in the light of their needs. No study, treatment, or training is an adequate piece of work which does not at all times very carefully conserve and protect the interests of the patient.

Practical Issues

There is an increasing emphasis in child guidance work on cooperation with other agencies, on the utilization of community resources, and on the development of the mental hygiene approach in all agencies working in the children's field. All these considerations emphasize the point that any training must be in the highest degree practical and fit individuals to work in a clinic which, being responsible to a community, is designed to meet community needs and demands and to cooperate with the community agencies. Not only that, but the individual must learn to work happily in a clinical unit where each member is responsible for certain sections of the work to be done with a patient. Given a good background of technical training in a particular subject, the individual worker still has much to learn concerning the above points, which

distinguish child guidance work from other types of mental hygiene effort as ordinarily conducted.

Clinical Units

It was obvious that a considerable load of cases would be needed to care for the training of the group of people already mentioned. A single psychiatrist could not possibly take care of such a case load and properly conserve the interests of the patient. Accordingly, it became necessary to establish three case-working or clinical units in the Institute staff, each with a psychiatrist (in charge), a psychologist, and two social workers. To each unit was then assigned its proportion of fellows and students, who became integral parts of the unit staff. In effect this gave three child guidance clinics, each a part of the whole and yet independent of the other.

Divisions

Aside from the organization of the Institute into clinical units it should be pointed out that there are three fundamental divisions which are not conceived of as departments, separated and isolated from one another, but as actual divisions of a coordinated whole. These divisions are the clinical, the social service (the two professional divisions), and the administrative.

The clinical division includes all psychiatrists and psychologists, the pediatrician and technician, and as such is the direct responsibility of the chief of staff. The social service division includes all social workers and students and is the direct responsibility of the chief of social service. The administrative division includes the clerical and stenographic staff (the responsibility of the executive assistant), the librarian and the statistical force. The executive assistant is responsible for the making and keeping of records, purchasing, bookkeeping and housekeeping, and for coordinating certain phases of the work in the library and the statistical division. However, the statistician and the librarian are each responsible to the director for the proper management of their own work. The entire function of this administrative division is to make it possible for the clinical work to proceed smoothly and effectively, and its duties and responsibilities are determined solely by the needs of the professional work of the Institute.

Clinical Division

Clinical Plan

The work of this division includes the physical, psychological and psychiatric examination of all patients, and psychiatric and psychological treatment when this is given. Its training work includes the training of fellows in psychiatry and psychology, as well as technical psychiatric contributions to the social work. The division is the immediate responsibility of the chief of staff, whose duties are essentially those of a clinical director and include only such executive matters as properly pertain to the clinical program of the group as a whole. It is also his responsibility to develop the research program of the Institute.

In order properly to conserve the interests of the patients and provide the best type of study possible, a pediatrician was appointed to examine all patients studied at the Institute, a small but adequate clinical laboratory was installed, and a technician provided to carry out those laboratory tests, chiefly in the field of clinical chemistry, which are from time to time required. For special examinations, such as X-ray, Wassermann tests, etc., arrangements were made with other organizations, including the city laboratory, to carry out the work, the Institute to pay the fees in case the patients' families were unable to do so.

Training Plan

While most of the training of psychiatrists and psychologists should proceed through the careful study of individual cases, certain sections of the training in psychiatric theory and its application to the treatment of behavior problems may well be done by the group method. The consultant in psychiatry was appointed to carry a seminar in case analysis for the psychiatrists and psychologists. Again, in training for practical child guidance clinic work, it is outstandingly necessary to give insight into the principles and practice of social work. If the training is secured in clinics which exist for the purpose of community service, it is done very largely by direct contact with social agencies and their work. Since the Institute does not exist primarily for purposes of community service, some specialized method became necessary. This was provided through the appointment of the consultant in social service whose responsibility it is to carry out this section of the training.

Social Service Division

Case Work

Social case work has become an integral part of the child guidance clinic's study and treatment of behavior problems in children. Accordingly a staff of supervisors and of fully trained case workers were provided. Two case workers were assigned to each unit to carry out the important task of social study and treatment. The division is the responsibility of the chief of social service.

Educational Supervisors

The New York and Smith Schools differ in their plans of operation and each group of students has a somewhat different relationship to the Institute. Therefore, it appeared necessary to have in social service an educational supervisor for each student group, charged with the responsibility of integrating the respective student groups, of analyzing the needs, potentialities and work of each student, and seeing to it that each had as well rounded an experience, coordinated with the School's program, as might possibly be given during the time spent at the Institute. These supervisors are a part of the Institute staff and responsible to the chief of social service, but appointed with the approval of the director of the School concerned. They act as liaison officers with the Schools.

Obviously these educational supervisors could not manage the detailed supervision of the clinical work of two such large groups of students as were projected. After carefully considering a number of possible methods, it was finally agreed with the directors of the two Schools concerned to allocate the students in groups to the *staff case workers,* they to be immediately responsible to the educational supervisors for the clinical work and experience of the students, who thus became in effect assistants to the staff case workers.

As cases are accepted they are assigned to the units as nearly as possible in turn and in the unit the staff case worker at all times carries the responsibility of the social work on the group of cases which have been assigned to her. Although expected to do case work herself she may reassign the responsibility for the immediate case work to the student assistants. There is, however, some change in the make-up of the student group every three months

throughout the year, with the result that the staff case worker must at all times carry the ultimate responsibility for her cases, which may be handled by some eight or more students.

Double Supervision

This in effect gives double supervision for each student. The staff case worker contributes intensive supervision on the details of work on individual cases to a small group of students. The educational supervisor has to do with the proper allocation of students, the evaluation of experiences for individuals and the group as a whole, and the relations of all this to the program of the School involved.

Supervisor in Social Work: Cooperation Work

Besides the educational supervisors, there was to be a supervisor in social service who should be responsible for supervising the case work of staff members. It was, however, necessary and extremely desirable to develop cooperative work with certain carefully chosen organizations which would assure a stable case load of the type of problems the Institute is prepared to deal with and would, at the same time, provide opportunity for training for cooperative work in communities. Accordingly, this supervisor was first set the problem of developing the cooperative work. Later it became necessary to combine with this the preliminary investigation of cases referred for study, as will be shown later in more detail. The position eventually came to carry the responsibility for supervision of staff work (though of this little was possible), of cooperative work, and the handling of the investigation of cases referred for study.

Make-up of Staff

Accordingly the staff was composed of the director, the chief of staff, consultant in psychiatry, three psychiatrists, three psychologists, pediatrician, and technician, a total of eleven, constituting the clinical division. The social service division was composed of the chief, three supervisors, consultant, the research assistant, and six case workers, making a total of twelve. The administrative division was composed of the statistician and two clerks, librarian, executive assistant, a supervising stenographer, necessary secretaries and clerks, a total of twenty. The total staff numbered forty-

three, of whom twenty-three would be classed in the professional divisions and twenty in the administrative division.

Number in Training

The largest number of people in residence for training was in the spring quarter, when there were thirty-two students from the two schools of social work, five fellows in psychiatry and three in psychology. The total number of individuals for the year was sixty-three.

IV. THE WORK OF THE YEAR

It seems best to analyze the work of the year in terms of its purposes. Accordingly it is discussed under four headings: clinical, training, research and miscellaneous.

Clinical Work

There is probably no need to elaborate on the studies which have been found necessary to understand and treat the problem child—thoroughgoing examinations in the social, physical, psychological, and psychiatric field are absolutely essential to grasping all the issues involved in a given situation. Actually, the process of obtaining much of the factual material is not very troublesome. Difficulties emerge when more remote material, either in time or in depth of emotional significance, must be secured if the case is properly to be understood. Most important of all is the interpretation and the use of the material derived from the several fields of examination.

Genetic Approach

Present-day psychiatric thought tends more and more to the genetic approach. The most clear-cut evolution in psychiatric thinking of which the writer is aware has been the recognition, particularly during the last ten years, of the continuity of mental life in relationship not only to the organic growth of the individual but to the experiences which he undergoes and survives. Thus a present behavior difficulty, whatever it may be, only very rarely emerges from a clear sky. Superficially it may seem to have done so, in the sense that the exact form of the behavior may be a new expression of the underlying trends in the individual. On the other hand, in investigating the history of the family and the de-

velopment of the child, a distinctive continuity is always to be found such that the present behavior difficulty can be shown to arise out of the material of the individual's life experiences, conflicts, complexes, etc. The behavior, whatever it may be, is purposeful in the sense of satisfying some need, real or fancied, of the individual, and is determined by his experiences and capacities.

Working with children one is able to demonstrate the interaction between individual make-up and the stimuli of the environment which have created the emotional reactions and behavior. Treatment is based on the recognition of this interaction and attempts to remove or modify the stimuli from the environment while developing in the individual child a greater insight into his own behavior.

These points of view are now universally recognized among social-psychiatric workers in the children's field. What their ultimate significance may be for the treatment of those end stages which are called the psychoses, or for preventive work in later adolescence or early adulthood, is not yet entirely clear. They are, however, very definitely shaping the trend of psychiatric thinking with respect to these complicated problems in human behavior.

Importance of Interpretations

The interpretation, then, of the material derived from case studies is the most important section of the work. If the interpretations are correct and really reach to the seat of the difficulties, a treatment plan may be formulated which has a greater than average chance of success. If, on the other hand, the interpretations are faulty and do not reach the deepest and most fundamental material, the chances of success are minimized. Indeed, in some instances the situation may even be made worse.

Conferences

The four-fold study made of each case must, therefore, be most carefully interrelated and the findings in each field interpreted in the light of the findings in others. The simplest and most satisfactory method of doing this is through a conference of the workers actually engaged on the case. Accordingly it is a routine policy to subject all cases to such a conference attended by all those who have studied the situation, and usually by all members of the unit staff who are not detained by emergencies. The first impression of many people attending such a unit staff

conference is that it is a considerable waste of time for so many people to be engaged in discussing and attempting to interpret the behavior of a single child. This viewpoint relates to the individual's notion at the time that such interpretations are very easily made and that treatment plans as a result almost automatically emerge. With developing experience, however, these workers come to realize that the interpretations are not easy, that the formulation of the whole situation needs the combined experience and judgment of the group, and that it is actually time-conserving to work out such matters in conference rather than by casting about as individuals and wasting time and effort through errors or false leads. If other agencies are involved in treatment plans, conferences are imperative for clear understanding. In another sense the conferences are of very real value because of their stimulating, thought-provoking qualities; because of the opportunity given to each individual to express ideas and beliefs which then come under the scrutiny of the entire group; and because of the opportunity they give to correct false ideas or impressions. They represent not only the most valuable portions of the case work because of the protection afforded to the patient's interests, but the most valuable educational measure of the Institute. In them attitudes are formed, the understanding of patients and their problems is developed, and accurate thinking is stimulated, as is the ability to accept criticism objectively.

Examination Outlines

One of the most difficult, yet most essential, points in the development of the clinical work lies in the erection of satisfactory and adequate outlines for examination and treatment. Receiving a great deal of attention during the year, tentative outlines for examination in each of the four fields—social, physical, psychological, and psychiatric—have been developed. These are constantly in the process of being refined through the exclusion of certain material which is found not especially profitable, the incorporation of new sections from time to time and the modification of items in accordance with their relative importance. These outlines of methods have not yet reached a form sufficiently stable that they may be sent out in answer to the many requests received from other organizations. They will probably be available in mimeographed or printed form some time in the second year.

To the practical worker in the field these outlines often seem unnecessarily detailed and to include some irrelevant material. This may be true for the *very experienced* worker but it is necessary that the outlines cover all the possibilities there might be in *any case* if the best of work is to be done. As experience develops, a differential sort of examination is possible in the light of certain gross or key phenomena which may very easily be found. It is precisely along the lines of preparing the proper sort of differential outlines that the attempt is being made to develop these forms. What has been done has proved extremely useful in unifying concepts, in laying the broad foundation for the proper sort of examinations according to the nature of the case, and for presenting material from the dynamic, genetic point of view.

Treatment

No such systematization of procedure is as yet possible in treatment. Treatment, in the sense of influence exerted upon a given behavior situation, begins with the first study contact, and at all times during the relationships with the patient the possible effects of what is done must be borne in mind. Indeed it is sometimes advisable to shift completely the ordinary routine of examinations, and in some instances work with the case has gone on from one to three months before the social examination data were finally available. In such instances it is usually necessary to deal with resistance in the family or in the patient to certain phases of study or treatment.

Routine of Examinations

Ordinarily, however, the social data are gathered first, then the child is examined at the Institute by the pediatrician, psychologist and psychiatrist. As a rule the psychiatric examination comes last in order that the psychiatrist may have the data from the other examinations to make sure of his leads and attitudes with the child. Each contact throughout this intricate process of study has its values in terms of the relationships established between the Institute staff and those people involved in the behavior situation. All steps, therefore, partake essentially of the nature of a treatment process. For practical purposes an artificial point is set up at which treatment is said to begin. This ordinarily follows the first staff conference, when plans are laid for an attempted readjustment of the situation. One of the major interests of the

Institute is the careful study of treatment processes in the attempt to evolve principles from what is being done.

Treatment Procedure

In general, treatment proceeds (as is common in child guidance clinics) through the joint efforts of psychiatrist and social worker and frequently the psychologist. The Institute does practically nothing in the way of physical treatment, referring cases needing such to the family physician (or family specialist) or to the clinics to which the patients would ordinarily go. So far as the major efforts are concerned, the most important phases of the treatment are contributed by the psychiatric social worker in her attempt to remold attitudes in the home, the school and elsewhere, and by the psychiatrist in his work with the individual patient, or, in many instances, with parents, where the psychotherapeutic problem is at a level beyond that to which the social worker is prepared to go. *There is here the application of psychiatric principles and techniques to the influencing of the social situation; and the shifting of various elements in the social setting to influence the psychiatric situation.*

Social-Psychiatric Treatment. This emphasis on social-psychiatric treatment is the keynote of practically all mental hygiene effort at the present time. Its evolution has brought such work to the point where diagnosis for diagnosis' sake is not regarded as particularly valuable. Instead, *diagnostic formulation* of all the issues in the situation is regarded as of value *only* as a means for the development of the treatment process. To the social worker, teacher, or parent the application of a diagnostic label to a child who is in difficulty may have some value, but increasingly these groups are demanding more than labels. What is wanted is some understanding of the situation (including all individuals important in it) and how it evolved, in terms of what may be done about it. This emphasis on treatment or, as it is commonly called, adjustment, in schools, social agencies, and the community at large, has necessarily led to a reformulation of diagnostic concepts. In practice, this has meant the interpretation and formulation of all the elements of the entire situation, instead of the application of a single diagnostic formula. Some of the leading psychiatrists of the country, notably Adolf Meyer, have long insisted that this is the necessary thing in psychiatric work; namely, to see all the

elements in the total picture which the patient shows, and particularly those upon which a reintegration of personality or social relationships may be built. This evolution in psychiatric practice accordingly is not so novel as it might seem: instead it is a logical development in the application of psychiatry to the problems of behavior and personality.

Treatment Conferences. Furthermore, it has been found necessary to pass the case under review from time to time in order that new findings may be evaluated in terms of the total picture and treatment plans modified not only according to their success but according to the new interpretations made possible by the material which comes out in the course of treatment. Oftentimes the most significant material is not obtained until some months after study has begun.

Case Work and Types of Service

Statistics of Case Work. The actual statistics respecting case work are given in tables at the end of the report. It is worth while to point out here, however, that in the course of the year 148 cases were received by transfer from the Bureau of Children's Guidance and 651 cases were directly referred from the community. Of these 651, 479 had actually been accepted and 42 were still pending at the close of the year. Approximately 26 per cent of the cases were referred by agencies in the social and health fields, the majority of them from those organizations usually classed in social service. Fifty per cent of the cases were referred by public and private schools, but some 70 per cent of these were for the consultation service. Approximately 19 per cent of the cases were referred by parents and relatives, and approximately 4 per cent came from all other sources. Of the cases accepted for the treatment service, approximately 44 per cent were referred by agencies, 31 per cent by schools, public and private, 20 per cent by parents and relatives, and 5 per cent from all others. Of the cases accepted for the consultation service, 5 per cent were referred by the agency group, 88 per cent by schools, 5 per cent by parents. These percentage relations give some picture of the differences in types and management of cases referred. From the schools, particularly the public schools, a considerable group of cases are now being referred for a special analysis (partial study) of reading disabilities in terms of "word blindness."

Types of Service Available. The Institute accepts cases for *treatment service* or for *consultation service.* In the former it assumes either complete (clinic) or partial (cooperative) responsibility for what is done. The social work in the latter instance is carried by the cooperating agency. On the consultation service, the study may be a "routine" study, in the sense of the fullest possible social, psychological and psychiatric study, or a "special" or "partial" study, meaning that the routine has been departed from in some way, either by a minimal study in all fields (special) or by a study in only one or two fields (partial). On the treatment service, whether cooperative or full clinic, there is the intention to carry out corrective plans: on the consultation service, only a report of findings is made. All cases are followed up at least once after contact has ceased in order to determine what the effects of Institute work are some six months after effort has been terminated.

Acceptance of a Case. Many factors enter into the question of acceptance of a case and its assignment to these special types of service. It has been necessary so far to make geographical limitations, such as that cases are accepted only from Manhattan and the lower Bronx. In other sections of the city the time spent in transportation is so great that a too small margin is left for case work itself. Certain types of problems are excluded because they do not fall within the general lines of Institute endeavor.

Cases are, however, not merely rejected. A number of data are required when a child is referred for study. These are very carefully considered and if the problem is, for any reason, not an acceptable one, the agency or individual interested is advised concerning further procedure—the organization which may be of service, etc. The various organized agencies in the city understand clearly the types of cases in which the Institute is interested. They have been most cooperative in their attitude when cases have not been acceptable, or when it has been necessary to defer action because of the size of the waiting list, or when special types of problems have been needed to fill in training needs. A circular of information was sent out early in the fall to all agencies and organizations that might use the services of the Institute. The following quotation from it expresses the general principles under which case selections are made:

Acceptable Types of Problems

In general, and within the limitations imposed upon its capacity by other functions, the Institute is prepared to give service in the cases of children (up to eighteen years of age) presenting problems in behavior or personality. Such children may conveniently be termed "maladjusted," in the sense that they show in their reactions to a group or to certain *real* situations which they are called on to meet (in home, school or the community at large) that there is a lack of adaptation between the child and the realities of life. There is no satisfactory way to classify the possible reactions, but the following groupings may be suggestive. In cases where an organization is in doubt the Institute will gladly advise regarding the possibility of giving assistance with a particular problem.

1. Children who present problems because of their socially unacceptable behavior (whether or not legally delinquent), such as: temper tantrums, fighting, teasing, bullying, disobedience, "show-off" behavior, truancy, lying, stealing, rebellion against authority, cruelty, sex difficulties, etc., shown at home, school or elsewhere.

2. Children who present problems manifested chiefly in personality reactions, such as: seclusiveness, timidity, sensitiveness, fears, cowardliness, excessive imagination and fanciful lying, "nervousness," excessive unhappiness and crying, stubbornness, selfishness, restlessness and overactivity, unpopularity with other children, and the like.

3. Children who present problems in habit formation, such as: sleeping and eating difficulties, speech disturbances (such as stammering), thumbsucking, nail-biting, masturbation, prolonged bed-wetting, and so forth.

Types of Problems Which Cannot be Accepted

The purpose of the Institute is to treat behavior and personality disorders, such as the foregoing, with the aim of preventing further difficulties, psychiatric and social. It has, in general, nothing to add to existing community facilities for the study and treatment of feeblemindedness, epilepsy, psychoneuroses, psychopathic personality, and the psychoses. Accordingly the agency should not refer a case if study elsewhere has resulted in such a diagnosis and a plan of treatment, unless there is an acute and difficult behavior problem demanding special service. Again, if the symptoms indicate the presence of one of the above conditions as the chief or only problem, the case would ordinarily not be accepted. However, in a child presenting socially disturbing behavior as the chief difficulty, the presence of symptoms of these other disorders would not usually deter the acceptance of the case for study and treatment.

The Institute is primarily interested in cases where there is reason to believe that a treatment program, designed to relieve the behavior difficulties, may be carried out with the child in his ordinary environments.

Advice Cases. A wide variety of special requests for information and advice are received by members of the Institute staff. So far as possible these are recorded and the initial handling of such requests is centralized in one person who may then pass on

the request to that member of the staff who is best fitted to deal with it. Advice is asked regarding special school placements for children presenting various types of problems; concerning summer camps; concerning private physicians to whom children may be taken for study; and a wide variety of miscellaneous problems about special bits of behavior, etc. It is not actually possible to record all these requests, as many come over the telephone, by letter, or in casual contacts. It has been necessary to evolve a systematic resource file of information to answer the questions presented. In general, the responsibility for the initial and perhaps final action on these requests rests with the supervisor to whom requests for the study of cases are referred.

Investigation of Cases Referred. During the early months the investigation of cases for whom study was requested (called elsewhere in this report "refers") was in the hands of the chief of social service. As this logically belonged with the supervisor developing the cooperative work, who was of necessity constantly having contacts with various agencies, the work was, at an appropriate point, transferred to her. The number of patients referred has increased markedly as contacts have widened. Approximately 20 per cent were not accepted and some effort was required in directing the patient to the proper agencies to secure the needed help. Investigation of refers and advice has come to occupy an increasing share of the time and attention of the supervisor. The investigation of refers is seen as one of the most important duties in the Institute, closely interlocked with the development of the cooperative work. For one thing, the person doing this work makes the initial contact of the Institute with the patient and those interested in him. Oftentimes several different people are involved in the situation, and an excellent opportunity is presented for establishing proper relationships between the Institute and other organizations, for individual case work and for educational effort in terms of the extension of the mental hygiene viewpoint and approach with individuals and agencies. As matters stand at present, the responsibility for investigating situations related to refers and their assignment to units is in the hands of one person, who is assisted by a committee drawn from the several professional groups of the Institute staff. The functions of this committee are, first of all, to evolve and formulate policies with respect to the acceptance of patients referred; and, more

particularly, to insure the development of a well-balanced case load which will meet the needs of the group as a whole.

Assistant. The supervision of staff social work, of the cooperative social work, and the acceptance of cases has become far too much to be handled adequately by one individual. Accordingly, an assistant supervisor will be appointed to participate in the investigation of refers and in the cooperative work.

Cooperative Case Work. It was originally intended to develop cooperative case work during this year. It was and is a special desire to establish a close working relationship with some one district of a family welfare organization, a children's case working agency or a division of it, one children's institution, a nursery school and one small school for older children. These organizations would be selected on the basis of their need for this type of service; their lack of such service; their willingness to cooperate in evaluating results; and their facilities for assisting in or carrying out treatment. Two tentative ideas have been in mind. One is that of doing work only on a limited and carefully selected series of cases, all of the social work being carried by the organization itself where it does case work, the Institute providing the clinical work and psychiatric social service supervision. The other plan would call for the selection of agencies and organizations having a case load sufficiently small to permit the Institute to serve as a consulting clinic in all the problem cases they might have. Probably it will be desirable to work out both plans, perhaps giving only one type of service to any individual agency. Consultation services, either by full or partial study (as previously defined), have already been made available in certain instances and have had good results, both in satisfying the needs of a special group and in providing the type of experience desired for those who are in training at the Institute.

Value of Cooperative Service. The cooperative service has three major points of value. There is the development of the mental hygiene approach and knowledge of technique, together with the greater understanding of the mechanisms underlying behavior, acquired by the workers in the organization with which cooperative work is being done. Second, and most important from the point of view of the Institute, is the opportunity afforded for all people in training to make contacts with these community agencies and their problems. While this is particularly important in the

case of psychiatric fellows, it is of value also to the psychologists and social workers. The ideals, aims, methods and limitations of an organization may be understood only through direct contact with it. The place of mental hygiene in the scheme of things, the practical difficulties in carrying out ideal plans for the solution of a given pernicious situation—these must definitely be visualized and methods for meeting them evolved if successful work is to be done by a community clinic. Finally, the cooperative work is extremely important because it gives certain stable sources for cases of quite varying types, such that a well-rounded and well-balanced case load may be more easily and more constantly maintained.

The fact that the cooperative work could not be completely established during the first year has turned out rather fortunately. It has given a longer time in which to consider the agencies and their needs; has provided a sufficient period for the agencies to become fairly clear concerning the contribution which the Institute may be able to make to their work, and has laid a relatively broad foundation on which the cooperative work may be inaugurated now that there will be sufficient personnel to manage the whole task.

Staff Social Work. During the winter it became clear that mature staff social work could not be had when the case workers must give their entire time and attention to the supervision of the case work being done by student assistants. Accordingly, a modification of the staff plan was made in January, such that two case workers were detached completely from student supervision and began to do independent case work, chiefly in cooperation with the fellows. Such students as these workers had been supervising were redistributed among the educational supervisors and the other case workers. This plan will be continued hereafter with a slight revision. So far each worker has carried cases into each of the various units, and has, therefore, come in contact with all fellows. For the ensuing year, there will be three such workers, one attached to each unit. This will make it possible, should it become desirable to do so, to change the worker from student supervision to case work, or vice versa, without in any way disturbing the orderly management of the unit.

Training

It is obvious from what has gone before that the problems of clinical work and training overlap in the sense that training needs must determine very largely the possible case load, and to a considerable extent the nature of the cases which may, at a given time, be accepted. Furthermore, problems of working methods, of success and failure in individual cases and the most effective utilization of case material hinge directly upon the caliber of the work being done by those in training. It is here that the necessity for careful, detailed and patient supervision becomes so essential if the patient is to receive the best service the Institute can give.

Needs. The needs of psychiatrists, psychologists, and social workers are different and the training plans for each group necessarily vary. Also, individuals vary greatly in their background of training and experience, so that to a considerable extent the problem of making their field experience most valuable to them must be more or less individually approached.

Fellows in Psychiatry

To receive appointment as a fellow in psychiatry the National Committee for Mental Hygiene requires that the candidate shall have the M.D. degree, preferably an interneship in a general hospital, and not less than one year of experience in psychiatry—preferably more—in a hospital with an active clinical service. In other words, a solid grounding in standard psychiatric theory and practice is required. The candidate must further have a willingness to go into organized community clinic work at the termination of the period, since the purpose of the grant is to increase available personnel for such work. Three fellowships were awarded in September and two additional fellowships in April. One fellowship holder resigned in June, two will complete their year's work in September 1928, and the number of fellowships will be increased from five to six.

Purposes of Training. It is not the Institute's duty to train fellows in the fundamentals of psychiatry. It *is* a responsibility to train the fellows to apply the fundamentals of psychiatry to the mental hygiene problems of children. The first purpose, then, of the training program is the provision of clinical experience with children's problems, which, especially in the beginning, must be

carefully supervised. In addition, the fellow must learn to work with and through other people in carrying out his study and treatment; to lead a staff group; the principles and practice of social work; how to organize a community for mental hygiene work and how to administer a clinic.

Fundamentally, this means that the fellows must understand thoroughly and accurately the potential contributions of social service, psychology and psychiatry to the solution of behavior problems. They must know the stuff of which mental tests are made, what the results mean and what the dangers are. They must know what social service can do, the kind of approach usually made to social problems, the tools with which social service works, and what contribution psychiatric technique can make to the solution of these problems. It is particularly necessary that they come to see the many weaknesses and gaps in present knowledge and technique, be prepared to face these and help to overcome them.

It is no easy task to take an individual who has been trained to do practically all his work himself; whose major satisfaction in work is derived from direct contacts with patients; who may not understand the possible contributions of social service; whose major reaction to mistakes of others may be one of impatient criticism; and, in the course of a year, convert him into a patient, understanding, probing individual, who views a mistake or a defect in technique only as a point of departure for investigation into causes and the elimination of such as a future error; to bring him to the point where he is content to do a great share of work through other people; to make him see the mental hygiene aspects of his leadership and of his relationship to others in the organization; to lead him to visualize a community as a clinical problem in mental hygiene; and to teach him so to organize his material that he can make it available for others. Perhaps the most important feature of the changes in attitude is that of substituting for a primary concern with diagnosis a real interest in the interpretation of findings in broad formulations and in treatment processes. This involves a realization of the fact that a single interview for examination is only rarely sufficient to bring out all the material which may be needed. There must also be developed a process of continuous interpretation of material as it is added.

The Program. It was obvious that to accomplish all these things much more would be needed than simply to have the psy-

chiatrist study a routine series of cases with such supervision as might be required. Accordingly, a broad and rather comprehensive program was followed, including case work under supervision developed as rapidly as the individual became actually fitted for it. The first step in such a program was and is, of course, to familiarize the fellow with Institute working methods and plans, and as various questions come up, explain to him the reason for the adoption of any particular procedure. At the unit staff conferences the theoretical and practical possibilities of the case are thoroughly discussed. It is particularly important to have some cooperative cases carried by the unit, so that *all* of the student group may become increasingly familiar with the problems, viewpoints, and techniques of the community agencies.

Examinations. So far as psychiatrists are concerned it is extremely important that they should carry a few cases through all the routine of examinations, including the securing of the social data necessary to understand the problems in behavior which the patient presents. Knowledge of theory and the ideas of others has been enhanced by participation in a seminar on the mechanisms of human behavior conducted by the chief of staff. Seminars on the psychiatric analysis of case material and on the principles and practice of social work have been conducted by the consultants in psychiatry and social work respectively. A seminar on the principles of the organization and operation of child guidance clinics conducted by the director hinged very largely on questions of community organization. Finally, there has been one meeting a week of all members of the professional group, at which one case was thoroughly discussed from every possible angle.

Value of Group Work. Much of this group work is primarily valuable for its indirect effect in the gradual shaping of attitudes and the gradual development of understanding of the reasons which underlie the methods which have been chosen. Mere verbal exposition of these reasons sometimes fails to convince, but as they become related to the actual practical difficulties of case work and community situations, the effect becomes pronounced. Although an integral part of a unit of the staff, the fellows are encouraged to make contacts with individuals in other units and with the work being done there. One visitor of the past year pointed out that the various clinics, with whose working methods and techniques he was familiar, were quite as individual as though they were

independent personalities. This occurs despite the fact that most of them utilize certain common techniques and certain common approaches to the problem. The same may be said of the clinical units in the Institute. Utilizing common techniques, common forms of procedure, and approaching their problems from much the same angle, they nevertheless vary considerably in the detailed working out of their programs in relation to individual patients. For purposes of stability, continuity of work and of supervision, it is desirable that the fellows' and other students' relationship to the unit shall be a fixed and continuous one, but it is also desirable that they should do a considerable amount of visiting in other units. Pragmatically, it is only through conferences, whether these be between individuals or in groups, that there is opportunity to develop a sound and well-rounded point of view in any person. Entirely aside from the value of these conferences to the patients in terms of the better thought-out planning which they permit, they constitute the most valuable procedure in the development of understanding, insight and ability to work with the group which has so far been found. Their value in these latter respects is directly proportionate to their value as case working conferences.

Fellows in Psychology

Psychologists present the same general type of problems, which are met in the same general way, as do the psychiatrists, but there are certain points of difference. It is less important that the psychologists should be fully conversant with the administrative aspects of clinic work. It is highly important that they acquire a socialized point of view; that they learn to work in units; and that they visualize the part which their findings actually play in understanding and treating the problems presented by a given case. So far the work of psychologists in treatment has not been fully developed. Certain efforts, such as the educational adjustment of a child in school, vocational planning, the development of sound mental hygiene attitudes in teachers, and special educational effort for children presenting some specific disabilities, represent the ways in which their greatest contribution to treatment procedure have so far been made.

Qualifications for Fellowship. The standards erected by the National Committee for Mental Hygiene for the appointment of psychological fellows were that they should be graduate students

majoring in psychology, possessed of the M. A. degree (or shortly to receive it), with a background of mental testing, such that they are familiar with the most commonly used tests. In other words, it is not conceived to be a function of the Institute to train them in the fundamental principles of psychology.

Functions of Training. The Institute conceives its function to be to enrich the clinical experience of psychologists in working with children; to increase their knowledge of treatment processes and community resources; and to fit them for work as integrated members of a professional team. They have, during the past year, attended the same seminars, staff conferences, and group discussions as have the psychiatrists. In addition, to insure an adequate volume of testing experience, arrangements were made with one school containing a relatively small number of pupils to do group and individual tests on all the children. As in the case of the psychiatrists, each has been attached to a definite unit, although free to carry a research problem in any of the three fields in which the three staff psychologists have specific charge. The fellows have been encouraged to attend the conferences of other units and to secure as broad and fundamental a foundation for future clinical work as could be had in the course of a year.

Volunteers

It had been a part of the Institute plan to provide, some time after the first year, an opportunity for a limited number of properly qualified psychiatrists, psychologists, and social workers to join its staff as volunteer assistants for the minimum period of time which should be profitable for them. It had not been planned to take any during the first year.

As it turned out, it became essential to provide for two psychiatrists. In each case the needs of the individual were gone over very carefully with him and a program outlined which would apparently give him the things which he most needed so far as they were available at the Institute. The work was experimentally planned, subject to change at any time. Each man spent three months at the Institute. On the basis of this experiment such applicants may more adequately be dealt with in the future. It is, however, now clear that, both by reason of space and training load, such men can probably be accommodated only during the summer months, which are apt, because of the diminished load of

work then being carried, to be less satisfactory than would the winter months. However, with the increase in the total number of fellows to nine and the necessary increases of staff and the large increase in the number of social service students to be carried, there is neither space nor time to devote to such purposes during the fall, winter and spring quarters.

One additional experiment in training in the clinical group is that of accepting a volunteer pediatrician who is desirous of increasing his fundamental knowledge of behavior problems. He devotes three mornings a week to Institute work and plans to do so over a considerable period. It is not yet possible to evaluate this experiment in any way.

Evolution in Training

So far as the training program for fellows in psychiatry and psychology is concerned, it has undergone a considerable evolution and therefore a number of changes during the year. Perhaps the major point lies in the clearer recognition of the period in training at which various elements should be introduced. The obvious first need is case work, done in considerable quantity in the beginning so that technique becomes more or less automatic. Following this, and yet to some extent overlapping, is the development of understanding of social agencies, their operations and problems. Material dealing with the organization and operation of clinics and the details of administration of such organizations logically comes in the latter part of the year, when the man is facing the problem of going into community work on his own responsibility.

On the whole the first year's program has worked out quite successfully. During the early months when the number of patients was small, some minor difficulties arose, but as the volume of work grew and the men learned through direct contact the complex nature and interaction of the many problems with which they were faced, the spirit of inquiry, of objective discussion and objective criticism became more and more developed so that the last six months of the year were quite satisfying both to staff and to fellows.

It is practically universal that people entering this field for the first time, no matter how excellent their background of training may have been (provided it did not include child guidance experience), go through a period of considerable bewilderment and

often discouragement; have considerable feelings of inadequacy and at times reject the whole field of work with the belief that it is valueless, over-elaborate and does not contribute. Such a period is expected by us usually about the third month of the individual's work, to be followed by an understanding of their own real, underlying emotional difficulties, such that they see the work in its proper light and relationships, and an enthusiastic, constructive child guidance worker emerges.

Social Workers

The issues to be met in training social workers differ a great deal from those so far discussed. In some sense at least it is a part of the Institute's function to train in the fundamentals of case work practice as well as in the fundamentals of mental hygiene technique. The worker must be trained to take her place in a clinical unit and become an integral part of the case working group, making contributions not only to the social-psychiatric technique but also from the viewpoint of general social work. If the student is new to field work, she must apply her background of theory in such manner that she meets the general case work issues adequately in her contacts with the community. If she is experienced in social case work but new in the psychiatric field, she must assimilate the mental hygiene approach into her ordinary practice. In either case, the student must establish herself in broad social work relationships while at the same time functioning with a clinical group and organization which she must constantly be able to interpret. In other words, the social worker in training cannot learn psychiatric social work as an entity without grasping the dynamic relationship between this field and generic case work, as well as putting into practice her knowledge of psychiatry in social diagnosis and treatment. Finally it is necessary to remember that many such workers will later not be attached to a clinical unit but will either be doing independent work or else work relatively independently of the guidance of a psychiatric unit. The training, therefore, must equip the worker to carry on independently or nearly so if that should become necessary.

Background of Students. All students, of course, must meet the requirements of their respective schools for entrance, and from the standpoint of their past training and experience two general

groups are encountered. The first is the group which has a background of social case work in a family welfare or children's organization, medical social service, schools and the like. This experience varies with the individual from a few months to several years. An experienced worker occasionally has some difficulties in resuming the student rôle. Often she makes unfavorable comparisons between the material of psychiatric technique and the material of her past case work experience. She may not be able to see points of difference or the ways in which the mental hygiene approach goes more deeply into fundamental psychological issues than was true in general case work. Because of her experience she frequently feels a greater need to see results. When additional equipment and technique do not seem to her, at a given stage of development, to accelerate treatment, she may minimize the value of the new technique. Actually, time is necessary for her to gain sufficient perspective to explore the situation and differentiate between the limitations of her handling of the technique, the limitations of a given situation, and those of the technique itself. Sometimes the experienced worker suffers from the small case load necessary to intensive work when she has not sufficiently assimilated the new approach to be able to effect treatment results to a degree that justifies in her mind the reduced rate of activity. Occasionally there is some resentment of supervision which must necessarily be given in view of the temporary nature of the student's connection with the Institute staff. This will be particularly accentuated if she finds any ways in which her experience seems to be greater than that of her immediate supervisor.

A second group of students are those without previous case work experience, who have perhaps just graduated from college or have done some work in a graduate school in some one of the scientific branches. Some of these students tend to foster their own dependence upon the guidance of others because, for the most part, that is what their experience in learning has been up to that time. The problem they present is primarily that of developing in them their capacity for working independently, grasping the viewpoints of other fields, the relationship of all types of social work, taking job responsibility and developing case wisdom.

Relations to Institute. From the standpoint of the relationships of the students to the Institute the situation varies very much. The Smith students are at the Institute for nine months of full-time

work, less certain hours spent in ways required by the school. Thus they have a half day each week for work upon the material which is eventually to be included in their theses, either on the necessary case work or some other feature. In addition they devote two hours a week to a course in general theory with particular reference to the case working methods of community agencies. Aside from this, however, their full time is given to the field work experience. They are all students in psychiatric social work.

In the New York School, students spend variable periods of time per week, and a varying number of months. For example, a total of forty-seven students from the New York School had been received in the Institute up to June 30. Of these, ten were in their first quarter during June and some may continue at the Institute during subsequent quarters. Of the other thirty-seven, thirteen had spent one quarter; twelve, two quarters; eight, three quarters; and four, more than three quarters at the Institute. The time spent varied from two days per week to full time in given quarters. Altogether seven of the forty-seven students had spent or were spending a quarter of full-time work. The majority were on a schedule calling for three days per week, the balance of the time being spent in theoretical work at the School.

Furthermore, in this group not all the students are majoring in mental hygiene, although the latter are given preference in places. Those who are majoring in mental hygiene usually spend three quarters at the Institute and ordinarily at least one of the quarters is full time. Other students majoring in some other field take one or, at most two, part-time quarters at the Institute for its possible effects in the development of their major interests in some other field of social work. Some of the students come to the Institute in the early part of their training. The majority, however, do not come until the latter part of their course, unless they are mental hygiene majors. This group, therefore, is not particularly uniform, either in its interests in mental hygiene work or in the amount of time to be spent in pursuing the Institute experience. The result is that, even more than in the case of the Smith group, individualized training plans and individual attention are necessary.

Students enter and leave the Institute each quarter and, as matters stand, no month in the year is entirely free from students

in training. Smith students are in residence from the early part of September until the early part of June. New York School students are in residence in all months of the year except September.

Thirty-five people have occupied the twenty-four places allotted to the latter School during the three quarters of the year. For the summer the number was cut down to sixteen as representing the normal group in proportion to available staff because of the vacation schedule.

Principles of Training. The principles of supervision in field work training for psychiatric social workers are in a process of continuous evolution. Among other things, the rapidly changing nature of psychiatric concepts as applied to social case work tends toward this. It is, however, certain that the social worker in training must learn psychiatric and mental hygiene formulations and particularly must develop the use of these in "case work" processes. Since her job is essentially that of developing and redeveloping attitudes in people, who may see absolutely no reason for any change in attitudes, or whose emotional problems block their perceptions, her knowledge of the underlying motivations of behavior and particularly of the emotional elements and their origin must be quite thoroughly developed, as well as an understanding of the emotional relations between worker and client, the management of dependence, emancipation, etc. Herein lies a very real danger, in the sense that in the course of so doing the worker may become unpleasantly conscious of certain motivations, drives, and attitudes of her own without being entirely clear concerning their final significance or ways of dealing with them. Here, as in other fields, a little knowledge is an extremely dangerous thing and it becomes peculiarly important to work out such trends or difficulties as they arise. While it is an open question how far a mental hygiene organization is responsible for the detailed working out of such matters when they emerge, it is clear that at least the organization must be cognizant of those special experiences, attitudes, drives, and bits of behavior which block the case worker herself when she is dealing with the problems of her patients. Though no hard and fast line can be drawn, the attempt is made to carry supervision to the extent of visualizing any difficulties in adaptation, emotional conflicts, unsolved drives, and so on, which, in the student worker, interfere with her success. To the individual staff

case worker whose duty it is to see that the social work is properly done on her load of cases, falls the primary responsibility for evaluating difficulties in the carrying out of case work and determining whether it is something in the student worker which is responsible. Difficulties in the student which may be met by interviews between staff and student case worker are so handled. Where the staff worker is not herself clear as to further steps, her first recourse is to the educational supervisor of the group to which the student belongs, then to the chief of social service and eventually, where there seems to be reason for it, to the director. This type of training implies an attempt at adjustment of the individual to herself and to her job on a superficial level in the sense of not probing too deeply into underlying mechanisms and in the sense of attempting to develop the solution through intellectual understanding of the issues involved. Some of the difficulties due to individual differences in the student are met by such indirect work with her as removing part of the pressure she may be feeling, by planning her work so as to increase her self-confidence, by placing in her way tasks which are familiar to her.

Where the student has a rich background in some other field she may present a stimulating challenge to the supervising staff, making particularly dynamic correlations between the present and past experience, and, if she has the maturity of viewpoint, she may make a real contribution to the evolution of methods.

There must be sufficient integration of the various elements of the work to make it possible for the student to identify herself with the Institute and make her maximum contribution in interpreting it to the individuals with whom she deals. Hence all those in training are regarded as temporary, junior members of the staff.

Fundamentally, therefore, the problems in the training of social workers are to take people of very different backgrounds of experience and training who are to be at the Institute for varying lengths of time, whose fundamental interests in the Institute work vary greatly, and in the time available give them as much insight as possible into the underlying mechanisms of human behavior in general, and perhaps of their own in particular; the application of all this to treatment; the mobilization of resources; interpretation of situations; and the working relationships of the psychiatric social worker to others in the various fields distinguishing mental hygiene effort.

General Considerations

It is obvious that the issues to be met in the training program are extremely complex because of the several different professional fields represented; the number of people in training in each group; the variations in procedure necessary to meet the needs of given individuals; and the number of people concerned in carrying out the work. The work of this first year has been necessarily, in large measure, of the nature of carefully developing organization and technique, critically evaluating the experience, and attempting to formulate methods and plans by which the work may go more smoothly in the future. One of the moot questions has to do with the size of case load which is necessary to accomplish the training. This particular issue is complicated by the fact that there are several different types of case work experience which are profitable for those in training. Probably the fundamental type of experience is that of carrying cases for intensive treatment. Certainly the larger share of training done should be devoted to such cases. These are routinely studied in considerable detail, discussed from time to time in conferences of the unit staff and a combined treatment attack carried out as intensively as may be needed over as long a period of time as seems profitable in terms of the working out of the case problems. From such detailed studies and intensive treatment there come the clearest ideas of the interaction of the various factors which produce disturbing behavior or personality traits. Such studies are time-consuming, and if the entire work of the individual were limited to such cases the number which could finally be studied would be insufficient to give a well-rounded experience with varying types of problems. It becomes profitable, then, for the student to study a larger number and variety of cases in less detail. There are various possible sources for such case material. The cooperative service can provide a certain amount of consultation work; special projects may be taken on, as, for example, the study of the children in one small school, undertaken in the spring and still continuing; and the development of a consultation service for certain organizations equipped to make use of it and having a load of cases which will fall within the limits of the Institute's possible consultation case working load. Also certain children referred by parents may be handled by a modified scheme of investigation, particularly in the social field, which enriches the experience of all without increasing materially the

load of intensive treatment cases. This type of service comprises some of the recognized values of history taking, short service, first interviews, etc. Practically speaking, every person being trained at the Institute should, at some stage in the experience, study a group of these consultation cases. In addition, the social service group who are majoring in psychiatric social work must have contact with the handling of referrals, the investigation of cases prior to acceptance and the giving of advice to those referring when the case is not regarded as a suitable one for Institute work. It is also essential that all should have some experience with cooperative work in preparation for community work where cooperation is so essential. Roughly speaking, a case load of about 600 per year will be required to meet the training needs of the Institute when the maximum number of students is reached (1928–29). Of these about 250 should at all times be under intensive treatment. The balance would then comprise consultation cases and intensive cases closed in the course of the year.

The Transfer of Cases. One inherent difficulty in the training situation is that as people leave the Institute, their cases must be transferred to other workers. All cases carried by students and fellows must be transferred at least once a year and transfers may be more frequent than this, depending upon the number of people in residence for one and two quarters. In all probability the interests of the patient suffer to some extent through these transfers and the issue to be solved by the Institute is that of minimizing any difficulties which may arise. This is not always easy to do, particularly when it is recalled that frequently the most valuable asset in treatment is the confidence which the worker has established in the client. In reviewing cases it is frequently seen that this confidence was not early established but only gradually came about, and the most significant material for the understanding of the actual behavior is not obtained until some weeks or months after study and treatment have been initiated. This is a very real problem in conserving the interests of the patients while, at the same time, meeting training needs.

Research

It is the desire of the staff of the Institute to formulate a broad but integrated program of investigations into clinical and treatment phenomena. This year, however, time and effort have

necessarily been spent in meeting the problems of organization and training. With some systematization in these it becomes possible to begin to do more intensive studies of groups of cases. Practically every member of the staff is interested in some special project which is being more or less rapidly evolved, and some of these may be worthy of publication. It is hoped that every fellow will select a project and write a thesis, for the training it gives in scientific method. It is also hoped that some members of the group may contribute new or original material.

The Smith students are required to present a thesis based upon some problem in their field-work experience, and some of the New York School students carry projects, utilizing Institute cases. With these, as with all other pieces of work which involve Institute material, it is necessary that a copy of anything written be filed at the Institute, and that nothing be published without Institute consent.

This is related to the hope of publishing, at irregular intervals, studies made on Institute material in the "Institute for Child Guidance Studies." These studies for the most part would consist of a selection of reprints of material published in standard journals, although an occasional monograph may appear for the first time. These are to be issued through the Division of Publications of the Commonwealth Fund. In all probability the first issue will appear some time during the coming year. A list of papers published by staff members during the past year will be found in the Appendix.

Miscellaneous

Statistics. One of the most difficult administrative problems in an organization of this type is the matter of statistical recording of work done and results attained, and the satisfactory indexing of cases so that they may later be available for research or other purposes. By special arrangement with the National Committee for Mental Hygiene, some 3,500 case records from the demonstration clinics have been deposited with the Institute. These records are chiefly of value for research and teaching purposes, and one of the first and most arduous tasks of the statistical division has been to index them so that they might become easily available.

Perhaps the greatest difficulty is the determination of what should be indexed. The Institute's active case material has been

completely indexed so far as immediate needs are concerned. In the meantime, ideas concerning the indexing have been evolved. After considerable deliberation a Findex system has been installed. A form of monthly report to be used for the Board and forms for recording work actually done have been worked out and are now in use. In addition to these more administrative matters, the statistical division has assisted in the working out of a number of research problems, as well as carrying some investigations of its own.

Library. Although a librarian was not secured until February, standard books and periodicals were purchased during the summer and fall of 1927. The library has seen a steady growth in the number and variety of volumes available and in the use made of it. In addition to caring for the technical aspects of library work, the librarian undertakes the compilation of bibliographies for various pieces of research which are under way, notation of books or articles important to individual members of the staff or Board, and the abstracting of French and German literature which may be particularly timely. These latter services are becoming increasingly important to the fundamental work of the whole group.

Board. The Board has met five times during the year with full attendance at each meeting except one. The annual meeting of the Corporation was held on March 5th. The annual meeting hereafter will be held on the day of the regular January meeting of the Board of Directors. At the 1928 meeting of the Corporation, all members of the present Administrative Board were elected to membership in the Corporation, so that to all intents and purposes the Corporation and Administrative Board became one and the same.

The Board is functioning through certain committees which are studying problems of case-work expenditure, the demands made on the Institute for teaching time outside the city, the responsibilities of the clinic staff for service on committees and giving individual lectures throughout the country, and the problem of publications.

The requests for members of the Institute staff to lecture and serve on committees have become extremely important and very difficult of solution, since many members of the staff are constantly being requested to perform such duties.

Extramural Activities

Committees. With respect to service on committees of other organizations, a policy is relatively easily established. National organizations with particular interests in this field, or local organizations which are closely connected in some way with the work of the Institute, have logical demands on the time of staff members. At the same time, the number of committees may become excessive for any individual, or the volume of work to be done on the committee may be out of proportion to the results obtained.

Lectures. Invitations for individual lectures or for short series have been received from all parts of the country. For the most part these center in and around New York and can usually be met if the request fits into the general Institute program in any way. Altogether some sixty addresses and papers have been delivered by various members of the staff during the year. It has been necessary tentatively to establish the general policy that staff members will not go out of the immediate vicinity of New York City to deliver lectures and addresses except for national meetings, the state meetings in which the Institute has a local interest or an engagement which reflects credit upon the organization as a whole, such as an invitation to deliver a lecture or short series of lectures at some important university.

Teaching. The third important issue in this field of extramural activity is the requests which are made for prolonged absences of members of the staff for teaching purposes. The conditions surrounding each request are apt to be such that they must be handled individually in accordance with the best interests of the Institute and its relationship to the institution which requests the service.

Other Activities

Visitors. In the course of this year 250 visitors from twenty-five states and nine foreign countries have come to the Institute to gain some knowledge of its purposes, methods of working, etc. Some of them remain for a week or more; others for only a few hours. In any case, interviews with various staff members must be had. It has been necessary to evolve a program for such visitors, involving the reading of case records and the discussion of case work and administrative problems with several people, including

usually the chief of staff, the chief of social service and the director.

Visiting Lecturers. Many of the distinguished visitors at the Institute have been prevailed upon to give lectures for the staff. Those who have done so were Doctors Bernard Hart, Samuel T. Orton, Herman Adler, Letitia Fairfield, C. Macfie Campbell, Adolf Meyer, and Miss Grace Marcus. By special invitation Dr. Alfred Adler gave a series of five clinical lectures.

V. PLANS FOR NEXT YEAR

The most important problems to be met relate to the increase in the number of people in residence for training. The New York School has been allotted thirty places, to include if possible the Commonwealth Fund English fellows. The Smith School will send between fifteen and eighteen students. The number of Fellowships in psychiatry has been increased to six; there will be one additional National Committee fellow. The number of fellowships in psychology remains the same. It has also recently been learned that several members of the staff of the newly organized Child Guidance Clinic in London will be at the Institute for periods of two and three months each.

All this will lead to some increase in the staff, through the appointment of an assistant to the supervisor of social service, three psychiatric social workers and one additional secretary. This will bring into full use all available office space, with no room for additional personnel. The number of students also reaches the maximum number which can be dealt with effectively and for whom there is space.

To our regret, Miss Eleanor Neustaedter, supervisor of New York School students, has resigned after a period of excellent service. The position will be filled by the promotion of Miss Sarah Swift.

Slight alterations have been made in the quarters to increase their usefulness and comfort. This was done by exchanging the former student rooms and the library and conference room.

The evolution of the manual of examination methods; definite formulation of the program of research; detailed study of the processes of supervision; development of the cooperative work; and further refinements of clinical and teaching methods represent the general lines of activity to be pursued.

VI. CONCLUSION

On the whole, this has been a very successful year with many real achievements. Often these cannot be statistically expressed: indeed, many of them may not be very well verbalized. As an organization, the Institute has become a closely knit group, with excellent morale and splendid working relationships such that interchange of ideas and opinions may go on very freely and without friction. Splendid cooperation has been received from all those agencies to which it has turned for help with its case problems. The Board has been patient, thoughtful and foresighted in its deliberations and a tremendous asset to the Institute. The staff has been loyal, hardworking and efficient. To all of these, collectively and individually, deep appreciation is due for the unfailing support, untiring effort and intelligent planning which made the success of this first year possible.

Respectfully submitted,

LAWSON G. LOWREY, M.D.,
Director.

Progress of Case Work

Table A. Analysis of Cases Referred

SOURCE	REFERRED			DISPOSITION			STATUS OF ACCEPTED CASES							
	Boys	Girls	Total	Not accepted	Withdrawn	Pending	Total	Treatment service	Consultation service	Closed	Active	Under treatment	Under study	On waiting list
A. By transfer from Bureau of Children's Guidance	97	51	148	0	0	0	148	148	0	79	69	69	0	0
B. Agencies														
1. Social	64	37	101	20	7	5	69	61	8	19	50	39	9	2
2. Health	19	9	28	3	0	2	23	22	1	4	19	12	6	1
3. Children's Homes	5	5	10	1	0	0	9	8	1	1	8	7	1	0
4. Settlements and Clubs	18	11	29	5	0	0	24	20	4	9	15	13	2	0
C. Schools														
1. Public	95	52	147	24	6	20	97	70	27	39	58	47	11	0
2. Private	65	120	185	3	1	0	181	8	173	135	46	6	40	0
D. Physicians	2	1	3	2	0	0	1	0	1	1	0	0	0	0
E. Parents and Relatives	74	49	123	49	1	10	63	51	12	21	42	31	11	0
F. Others	17	8	25	7	1	5	12	12	0	1	11	8	3	0
G. Totals, all sources	456	343	799	114	16	42	627	400	227	309	318	232	83	3

TABLE B. SERVICES GIVEN ACCEPTED CASES

	Cooperative study	CLINIC STUDY			
		Routine	Special	Total	Total
A. Treatment Service					
1. Total number	33	357	10	367	400
2. Closed	1	126	5	131	132
3. Number active at end of year					
(a) under treatment	29	202	1	203	232
(b) study incomplete	2	28	4	32	34
(c) on waiting list for study	1	1	0	1	2

	Routine study	Special study	Partial study	Others	Total
B. Consultation Service					
1. Total number	3	56	182	2	243
2. Closed and transferred					
(a) closed	2	14	159	2	177
(b) transferred to treatment service	0	7	9	0	16
3. Number active at end of year					
(a) study complete	1	8	0	0	9
(b) study incomplete	0	27	13	0	40
(c) on waiting list for study	0	0	1	0	1

TABLE C. RESULTS OF TREATMENT

CLOSED CASES FROM TREATMENT SERVICE ONLY

Duration of contact	Satisfactory adjustment	Partial adjustment	Unimproved	Total
1. Less than 1 month	3	4	0	7
2. 1 to 6 months	9	22	1	32
3. 6 months to 1 year	8	18	6	32
4. Over 1 year	0	0	0	0
Total	20	44	7	71

Number of Treatment Service cases closed before beginning of treatment, 59. Status not yet determined, 2.

TABLE D. NUMBER OF ORGANIZATIONS REFERRING CASES

	NUMBER OF CASES				
	Number of organizations	Accepted	Referred to other agencies	Pending	Total
Agencies, social and health	65	125	36	7	168
Public schools	40	97	30	20	147
Private schools	10	181	4	0	185

TABLE E. AGE DISTRIBUTION ("PENDING" CASES EXCLUDED)

	ACCEPTED CASES			REJECTED AND WITHDRAWN CASES		
Age	Boys	Girls	Total	Boys	Girls	Total
Below 6	13	15	28	7	3	10
6 through 11	172	118	290	31	13	44
12 and over	153	155	308	56	20	44
Unknown	1	0	1	25	7	32
Total	339	288	627	119	43	130

Table F. Problems as Referred

FORTY MOST COMMON COMPLAINTS OF THOSE REFERRING PATIENTS

Problem Referred	Number of Cases
Disobedience, uncontrollable, etc.	42
Stealing	32
Temper	29
"Nervousness"	28
Lying	24
Disturbing behavior in school	20
Truancy, school	20
Truancy, home	20
Retarded in school	17
School failure	15
Enuresis	15
Masturbation	15
Quarrelsome	14
Destructive	9
Fighting with other children	9
Reading defect	9
Shy	9
Sleep disturbances	9
Stays out late	9
Fears	8
Does not get along with children	8
Restless	8
Sensitiveness	8
Undesirable companions	7
Excess phantasy	7
Impudent	7
Mother protective	7
Overdependent	7
Physical defects	7
Sex activity	7
Stubborn	7
Unhappy	7
Defective concentration	6
Cries easily	6
No friends	6
Irritable	6
Irresponsible	6
Obscene language	6
Annoys other children	6
Speech defect	6

TABLE G. DISTRIBUTION OF INTELLIGENCE IN PATIENTS STUDIED

I. Q.	Boys	Girls	Total
Below 70	3	4	7 (1.5%) (feebleminded)
70– 90	52	42	94 (20%) (below average)
90–100	59	49	108 } 215 (46%) (average)
100–100	53	54	107 }
110–160	81	66	147 (32%) (superior)
Totals	248	215	463

ESSEX COUNTY JUVENILE CLINIC

THE PLACE OF A MENTAL HYGIENE CLINIC FOR CHILDREN IN THE COMMUNITY [1]

J. S. PLANT, M.D.,

Director

Essex County Juvenile Clinic, Newark, New Jersey

The Essex County Juvenile Clinic was established by the Board of Freeholders of that county six years ago. It is under Overbrook Hospital and the Director makes his reports, requests, and so forth, to the superintendent of that hospital. The clinic staff consists of a psychiatrist and a varying number of psychiatric social workers (2 to 5)—together with stenographic help. In most of the similar clinics throughout the country there is also a psychologist; it just happens that, with us, the psychologist and psychiatrist are combined. The value of this last arrangement is open to question but it allows of an intimacy of contact between the child and the person studying him that outweighs any other considerations. The expense of such a layout is about $20,000 per year.

This clinic has two distinct functions. Between these there is an interlocking which defies clear analysis since the clinical and teaching functions are mutually dependent upon each other. The clinical function resolves itself into accepting about 450 new patients each year, with a constant and persistent follow-up on every patient seen. This frank and unending follow-up with the notion of trying to discover whether the recommendations are of value is an extremely important part of the clinical function. The teaching function is harder to picture. The handling of the various conduct disorders—bed-wetting, thumb-sucking, shyness, bullying,

[1] Reprint from the *Journal of the Medical Society of New Jersey*, 1929. Read at the 163rd annual meeting of the Medical Society of New Jersey, Atlantic City, June 13, 1929.

laziness, day-dreaming, stammering, masturbation and psychoneurotic symptoms of all sorts—must eventually lie in the hands of parents, teachers, nurses, the policemen on the beat, in fact, precisely in the hands of those who at the earliest moments can in sane and simple ways make what are then simple adjustments. This means constant lecture work to groups, constant planned "demonstrations" of what our goal is, constant planning and advising in what amounts to a vast program of social engineering.

Clinical Functions

The clinical function is of great interest to the general practitioner. The first of these clinics was established by Dr. William Healy in Chicago in 1911. It represented the application of the physician's point of view to the problems of crime and delinquency. The lawyer is interested in the question of the existence of a fact. Did Johnny steal the money, and how much did he steal? The physician looks upon the stealing as he looks upon a fever—as a symptom. Why did Johnny steal and what does the stealing mean? We physicians look upon disease as the reaction of the normal body to abnormal conditions. Virchow taught us that fifty years ago. Thus we often see the most distressing physical symptoms as no more than signs that the body is not in essentially good condition. Take a meningitis as an example—who does not dread the low temperature and the insidious symptoms? That is, the physician comes to the problems of children's maladjustments with a distinctly new social philosophy. To these disorders he applies a method of diagnosis and the delinquency or mental habit has only the same value that has any symptom.

In making this diagnosis the psychiatrist attempts to acquaint himself with the total make-up of the child and of his environment, past and present. This means first of all a physical examination—looking for the poisons that sap and irritate, the malnutrition that fatigues, the glandular disorders that bespeak emotional imbalance, the gross heart lesions that lead to abnormal means of winning a place in the world because the normal channels are blocked. This accounts for some 10 to 15 per cent of the cases.

Then we employ a series of psychologic tests. Here we measure the intellectual ability, find the intellectual assets and liabilities, mayhap find the reason for failure in school, or in one particular

subject, make possible more accurate prognostications as to how far the child can go in academic work, and so forth. Wrong school placement, either in too high or too low a grade or in special subjects too hard or too easy, is an extremely important source of the frank truancy or even the vaguer dissatisfaction and unhappiness that are the forerunners of more serious difficulties. We have here also the problem of those who are frankly defective. These latter make up 25 to 30 per cent of our problems.

There is then the psychiatric examination or what we term the "own story." This means a one or two hour talk with the youngster about his life from the earliest time he can remember. Who were his playmates, what were his ambitions, where was he thwarted, what does he like, how does he stand that angelic brother of his, with whom does he play, and what does he play? In fact, we try in a brief way to retrace the youngster's whole development. It is fatal to start, as does the lawyer, from the present trouble. The story is then merely a justification of the present situation. For instance you cannot get a boy's confidence in asking him about his masturbation or directly "accusing" him of it. In fact you usually, with this method, only serve to make him all the more terribly feel that this guilty, sinful act is proclaimed in his eyes, his gait, his attitude. On the other hand, he is quite free to tell you of his first bad neighborhood, the first dirty words, the later corner gang that talked about these things, and the boy who "kidded" him into trying it as an experiment. Here you get the diagnosis as a picture of a series of events and the boy talks his present problem with you frankly because you have lived through its genesis with him.

These "own stories" are intensely interesting and varied. Time alone prevents the recounting of many that show the actual delinquency or peculiar mental habit to be nothing but the child's quite immature but thoroughly normal attempt at solving a problem. I stop to say but one thing—that there is no cause for crime; the way to difficulties of life is as variegated as life itself. It is just as ridiculous for us to talk of the cause of crime as it is to talk of the cause for headache, or the cause of a rise in temperature!

Paralleling this study of the child, a psychiatric social worker makes a similar but, of course, less exhaustive study of the environment. She must know the boy's stock, the instabilities or stolidities that are the basic fabric of his life. She interests herself in the

ambitions and disappointments of the parents and teachers; all those drives that seek relief in working out in some child the life the adult wished that he had led. Relatives, scout leaders, ministers, neighborhood—wherever she can find the influences and drives that have touched the child's life, there she goes.

The result is a genetic picture of the trends of the child's life, a realization that the present difficulty is but the expected outcome of a series of influences. For young children the social worker's study is the more vital; for older children the trends within the child himself become more important. This summarized picture, with the suggested therapy, is returned to the referring parents, teacher, judge or physician.

These clinics started working largely with adolescent children in the courts. What has been said so far must lead you to realize that we are largely interested in prevention and that there must be every tendency for us to try to reach earlier situations. Thus we have been interesting the schools in getting at their problem children. In Essex County there is already a school program four times as large as our court program. You will perhaps sometime hear Dr. Bruce Robinson who is a part of that school program. Now, we are going more and more into a preschool program. A county clinic means nothing if it is not spreading this physician's point of view—this medical philosophy—into every nook and cranny of the family life of the county. Each day finds us a little more able to reach prevention. That is the keynote of modern medicine and the psychiatric clinic is nothing other than the introduction of the medical point of view into a new field—the field of social engineering.

The therapy depends, as elsewhere in medicine, upon the diagnosis. However, there has been on the whole the development of a better diagnostic than therapeutic technique. The field is new and in all of its branches we have a long way to go, but we have gone further with our diagnosis than with our therapy. We would stress however that, much more than in any other branch of medicine, there is usually a tremendous lessening of the stresses of the situation when their source is opened to view. We are all acquainted with the relief that comes from "talking over" a situation. There is a certain objectivity about placing a situation before oneself that of itself remarkably relieves the total situation.

Teaching Function

The teaching function is quickly described, although it is perhaps more important than the clinical function. After all, there are large factors of teaching involved in each case. We know too little about the total personality to treat it directly; thus, much of the therapy is the matter of teaching the child how to find happiness and his parents how to let him do this. Beyond this lies a large zone of teaching which we largely do through giving courses in the problems of conduct disorders to nurses, teachers and probation officers. We earlier did a great deal of lecturing to parents—separate lectures to different groups. This we have given up because the contact is too short and the parent gets from the lecture only what he or she wants to get.

There is a further teaching function that is difficult to state in a few words. I have attempted to show that we are dealing with a new point of view as to the conduct of people. The matter of spreading this doctrine, of teaching to all of the people that the conduct which they see and themselves display is but a symptom of underlying personality traits and drives—that, in an age of materialism and overweening interest in facts as opposed to those more basic factors which we might term the "spiritual" aspect of life, is of the deepest importance and amounts to an educational program of vast magnitude.

Conclusions

A word in conclusion. Why is this work of interest to physicians? We are living in an age of unprecedented stress. Crime is our biggest business; there are as many beds, in this country, for the insane as for all other sicknesses combined. You cannot prohibit unhappiness by a constitutional amendment; you cannot suppress crime by a series of stringent laws; you cannot prevent insanity by keeping here and there a few people adjusted outside of a hospital, or by pridefully pointing to a few more paroles. If William James could in 1890 picture the new-born babe's vision of the environment as a "big, blooming, buzzing confusion" what would he say of these vast urban conglomerations of 1929? The harvest we are reaping is jail upon jail, hospital upon hospital, your neighborhood filled with tense, on-edge, striving, competing individuals. For this the mental hygiene clinic does not offer the

solution. But it does offer a new scientific reasonable approach. It offers the method and philosophy of the physician—the idea that these phenomena are but symptoms—and that there can be no real therapy until there is diagnosis, no real diagnosis that does not entail prevention. I ask you to seriously gaze upon the vision that what you have done for tuberculosis, what you have done for diphtheria, what you have done for typhoid, you can do, by your methods, for the deepest and most sinister of all human ailments —unhappiness.

This is a challenge!

Psychiatric Social Workers

The following clear statement by Mildred Scoville who has had clinical experience and is now in administrative work with the Commonwealth Fund is given in full, together with the questionnaire which was sent to her.

The following questionnaire was sent to the New York School of Social Work; Smith College School for Social Work; American Association of Psychiatric Social Workers; and to the Social Service Department of Massachusetts General Hospital.

QUESTIONNAIRE

1. The Subcommittee on Psychology and Psychiatry is trying to collect opinions and facts which will enable it to report recommendations concerning its very large and ill-defined field. Its members are particularly anxious to give the physician in general practice a clear idea of his duties and opportunities. The place of psychiatric social work is one of the elements which are confusing us. We have, of course, no reservations about the psychiatric social worker who is working with a psychiatrist. The problems that come up when the psychiatric social worker is not so associated seem to us distinctly puzzling. We have written a series of letters to psychiatrists and others and have a good deal of assorted opinion, but very few facts. There is, of course, an expected agreement that psychiatric social workers are extremely valuable, but two doubts are expressed.

2. One comes from individuals who are familiar with medical social service. Some of these people question the adequacy of the training of psychiatric social workers in basic medical social work. All of the Committee realize the shortness of life and the vastness of its problems, but do you feel that the psychiatric social worker has adequate background?

3. Another objection is often expressed by doctors. Essentially

it amounts to this. Various people assert that psychiatric social workers at the end of their training know more psychiatry than the average graduate in medicine. The inference is that they are better psychiatrists. This stirs up the doctors a good deal. Their inclination is to resent the idea that anyone can excel in a medical specialty without a preliminary medical training. We grant that a good deal of hurt pride, etc. is involved, but there's something wrong all round. Would you be willing, for our committee, to formulate answers to the following questions?

4. What, aside from the obvious duties as aides to psychiatrists, do you regard as suitable fields for psychiatric social workers?

5. Do you feel that organizations not supplied with direct and competent psychiatric supervision can gain from the presence of psychiatric social workers? I ask this question largely because I am sure that a useful field exists here, yet I am not clear as to how much independent work is desirable.

6. What is your feeling as to the future? For some time to come, of course, psychiatric social workers are going to be in demand for conventional psychiatric clinics. Is it your idea that the special schools will provide for this field only or do you see other opportunities.

7. Granting that psychiatric social workers have a special training more elaborate than other medical social workers, do you see opportunities to act as teachers of other groups or do you think that other workers should receive, in shortened form, training at psychiatric centers? All this, of course, leads to a question of policy. On the one hand, the medical social worker feels, I think, that much of her work is in "adjustment" problems, while I judge that certain psychiatric social workers feel that "adjustment" should be done only by their own group. I recognize that you may feel that the previous questions do not bring out pertinent information. In that case can you propose and answer questions which outline the general field of psychiatric social work? This letter is sent you in order to supplement and clarify data of various sorts and not in order to stimulate controversy. One of the few contributions this Subcommittee can make is to argue in private about controversial matters and to do this we are trying to collect our explosives quietly.

EXCERPTS FROM REPLIES TO QUESTIONNAIRES

1. The General Field of Psychiatric Social Work

Social case work deals with human beings who have found difficulty in the conditions of social life in making their way to acceptable organization of existence. Self maintenance is the product of a reasonably adequate human equipment adjusting itself to a reasonably favorable environment. The chief objective of social case work is to assist individuals who need such service to achieve what may be for them as complete a measure of self-maintenance as possible. This objective might be itemized as an attempt to develop within the individual his fullest capacity for self-maintenance and at the same time to assist him in establishing for himself an environment which will be as favorable as may be to his powers and limitations.

Psychiatric social work is that branch of social case work that deals with cases of social maladjustment in which a mental factor or a behavior problem is of primary importance. All social cases have a psychological aspect, but psychiatric social work is concerned particularly with those in which the mental problems predominate and require attention. Because of the many relationships between an individual's social situation and his mental concepts and between his mental life and his social behavior a consideration of social factors is important in most mental difficulty, and the social worker brings to the psychiatric problem her special skill in evaluating social data and in effecting environmental adjustments. The aim of all psychiatric social work is to contribute to the improvement of the individual's mental health and to assist him to make a better social adjustment.

2. Some individuals familiar with medical social service question the adequacy of the training of psychiatric social workers in basic medical social work.

Social case work is carried on almost universally through the medium of organizations which, with few exceptions, represent a specialization in the field. The different forms of social case work confine themselves to different phases of the whole problem of self-maintenance. Specialization in this sense makes necessary variations in the approach of different forms of case work to these distinctive problems and to some extent variations also in methods of work. This differentiation of organization permits a concen-

tration upon particular forms of human difficulty. The administrative requirements of the different fields of social case work require different degrees of familiarity with different kinds of subject matter—psychiatry for psychiatric social work, medicine for hospital social service, and so forth.

The fields of medical social work and psychiatric social work represent highly developed special adaptations of social case work to one of the older and more definitely organized professions, that of medicine. As medicine, which is so broad and so varied, has developed both in training and in practice a series of specializations which can be roughly grouped under physical and mental, so social case work, equally broad and varied, has developed similar specialties for a working coordination with these fields. The medical social worker and the psychiatric social worker relate both in training and practice to the parent field of social case work exactly as the internist or surgeon or general practitioner and the psychiatrist relate to the parent field of medicine. The *basic* training for one field is general medicine, for the other, generic social case work.

The need for adequate working knowledge of the social implications of disease is apparent for all social work practiced in association with the medical profession. From a study of approved courses of training in psychiatric social work it is believed that most of them provide theoretical training along the lines of "social medicine" adequate for the general fundamental orientation of the psychiatric social worker as necessary equipment for the usual demands of positions in that specialty. On the other hand, it is granted that the medical social worker has in general received a more intensive training in all aspects of "social medicine" since this comprises the content of her specialization. The psychiatric social worker needs and usually has good working knowledge of social medicine and adequate general grounding in the relationships between social case work and general medicine but she does not have such complete training and experience in all the ramifications that should be a fundamental part of training for medical social work. Psychiatric social work and medical training for medical social work, as separate specialties of the social case-work field, concentrate both in training and practice upon different types of problems and frequently function according to the demands of different administrative settings.

3. Another objection expressed by physicians is that psychiatric social workers at the end of their training know more psychiatry than the average graduate in medicine.

A distinction needs to be drawn between the medical specialty, which is psychiatry, and mental hygiene, which in many of its aspects is not psychiatry. The psychiatric social worker does not consider herself a specialist in psychiatry, which is distinctly a branch of the profession of medicine and requires a thorough medical background. She definitely represents another professional field which, because of the very nature of its functions, closely and inevitably approaches the broad field in which the psychiatrist operates in dealing with personality difficulties and adjustments.

The psychiatric social worker in her equipment must be adequate primarily in the knowledge and skills of social case work and secondly in scientific knowledge about personality and human behavior and in an understanding of the principles of physical and mental health. Such training implies the acquirement of an understanding of human relationships and of emotional values and of a technique for effecting emotional adjustments.

The psychiatric social worker must receive such fundamental training in social case work and in knowledge of human behavior and relationships to make it possible for her to function on a professional level in a field requiring distinctive contributions along the following lines quoted from *Social Case Work:* [1]

> "Ability to formulate psychiatric social diagnosis and treatment steps based on an analysis of interrelationships of clinical examinations and environmental factors in the social data, both symptomatic and causative, in the case situation.
>
> "Ability to formulate the social interpretation of the psychiatric, the psychological and the physical findings, and carry out the treatment, for any individual in the situation, controlled by appreciation of the motivation, causative factors, and the recipient's present ability to understand and assimilate this material. (Whether applied to a member of the patient's family or to school or other professional per-

[1] Quoted from *Social Case Work: Generic and Specific.* An Outline published by American Association of Social Workers, 130 East 22 Street, New York City, 1929.

sonnel, this is part of the treatment of the patient's situation.)

"The ability to elucidate the problem stated in terms of symptomatic behavior and to gather significant social data in the form of a differential history for the purpose of supplementing the psychiatric, psychological and physical examinations on a particular psychiatric problem.

"Ability to assume direct responsibility for dealing with the personal attitudes and modifying the personal relationships which contribute to the psychiatric problem but which in the opinion of the clinical group are more readily susceptible to the psychiatric social worker's influence than to that of the psychiatrist.

"Ability to formulate the application of psychiatric social work content to the professional activities of a non-psychiatric group.

"Special orientation and ability necessary to interpret to an agency or an individual in the abstract or as part of case treatment, the function and scope of institutions concerned with custody and treatment of individuals with mental or personality deviations, i.e.: neuropsychiatric hospitals, neuropsychiatric clinics, institutions for the feeble-minded, or courts, where they are concerned with matters of commitment.

"The ability to interpret to psychiatric clinical staff, effectively for the case, the functional potentialities of a participating, non-psychiatric agency, and that agency's need for comprehending the psychiatric problems and treatment indicated.

"Ability to adapt psychiatric social work content to an educational program for the protection of the individual and the group against mental disease, delinquency, and socially unacceptable behavior."

The objection in the heading should not be met by giving the psychiatric social worker *less* training in social psychiatry. The solution is for the medical schools to give *more* training in psychiatry so that the graduate in medicine will have as great a fund of knowledge as the social worker. At present many medical schools have a smaller number of lecture hours in the field of

psychiatry than the schools of social work that specialize in psychiatric social work.

4. What, aside from the obvious duties as aides to psychiatrists, do you regard as suitable fields for psychiatric social workers?

Since the psychiatric social worker represents a definite professional field from which she is equipped to make distinctive contributions to the understanding and treatment of social maladjustments she should be considered as an important ally to the psychiatrist, rather than as an aide; and her functions should be limited only by the boundaries of her professional field. These points are stated at length in the report of *A Survey of Mental Hygiene Facilities and Resources in New York City*[1] from which the following is quoted:

> "The psychiatric social worker's functions in a clinic may be described as twofold: case work and general activities. Her contribution to the work on individual cases should be her fundamental contribution. The implications of this carry her into staff and outside relationships which are important obviously to the case work and also to the position occupied by the clinic in the community. She must be prepared to discuss new cases when necessary with referring agents or with patients themselves. She must prepare histories with due appreciation of treatment implications, as well as diagnostic. She must be able to formulate the social interpretation of the psychiatric, psychological and physical findings with an appreciation of motivating causative factors, to take an active part in discussion and evaluation of these as well as to assist in the formulation of treatment plans. In treatment itself, she should be able to take an active part. This may be accomplished through use and manipulation of social environmental factors, such as existing conditions in schools, jobs, courts, and so forth, through interpretation of patient's problems and through effecting in the attitudes of other individuals better approaches to the problem. Or it may be accomplished through effecting

[1] Quoted from: Report of *A Survey of Mental Hygiene Facilities and Resources in New York City* for The National Committee for Mental Hygiene and New York City Committee on Mental Hygiene of the State Charities Aid Association, July, 1929.

adjustment of personal difficulties contributing to patient's problems of those individuals who may comprise his immediate milieu such as parents, spouse, siblings, and so forth, or of the patient himself when indicated.

"It is desirable that the social workers have the ability to dovetail the psychiatrists' treatment in dealing with personal relationships which contribute to the problem and which may be more readily susceptible to the psychiatric social worker's influence than to that of the psychiatrist.

"The psychiatric social worker's functions in a clinic in the clinic are manifold. Since she is on a full-time basis and must often represent the psychiatrist and clinic staff, she is fully aware of their objectives. She must function as a coordinating agent between the clinic and the community carrying across the mental hygiene point of view to the community and, equally important, interpreting community thinking and handling of reality issues to the psychiatric staff. Because of her many points of contact in and out of the clinic she often assists in the formation and execution of clinic policies and in the correlation of clinic activities."

As consultants in social and health agencies, psychiatric social workers can materially assist those agencies in a more efficient and intelligent use of mental hygiene facilities and in a better understanding of the mental hygiene point of view. Such work does not repudiate the psychiatric clinic but is rather a valuable adjunct to it. Mental hygiene rather than scientific clinical psychiatry is the concern of all professions dealing with individuals.

Organization and education work in national, state and city societies for mental hygiene affords an opportunity for the psychiatric social worker to utilize her knowledge and training in disseminating sound mental hygiene information and in arousing interest and raising standards of work.

Also the psychiatric social worker functions independently in training courses for social work.

The first and still most extensive use of psychiatric social workers is in connection with clinics and hospitals, centers from which the psychiatrist works and to which persons with emotional behavior and mental difficulties are referred. However, as knowl-

edge regarding and recognition of the need for mental hygiene have developed, the field of psychiatric social work practice has extended markedly until it now embraces positions in schools, courts, social agencies, public health agencies, institutions and industrial plants either with or without a staff psychiatrist. If a psychiatrist is not present, the position is chiefly on a consultation and educational basis, with regard to the mental hygiene and psychiatric social implications in situations handled by the organization.

5. Do you feel that organizations not supplied with direct and competent psychiatric supervision can gain from the presence of psychiatric social workers?

The psychiatric social worker may function effectively in social, health and educational agencies of all types where special concern is had with personality deviations and social maladjustments. The wide range between the social problems that arise in connection with acute mental disorders and those involved in mild personality maladjustments and the faulty childhood habits results in a considerable divergence in emphasis in various psychiatric social work positions. Mental hygiene needs and personality problems are so widespread among the clients of social and public health agencies that if all were placed under the care of clinics it would swamp the psychiatrists. There is undoubtedly a distinction, at present scarcely defined, between the situations requiring active psychiatric study and therapy and those requiring social mental hygiene study and assistance. Psychiatric social workers who have had adequate training and adequate clinical experience are equipped to study and recognize the needs of the situation and to give both agency workers and clients help that is much needed in determining the course of action to be pursued. The most valuable contribution in such positions as consultants in social agencies should be in giving to other workers sufficient knowledge and insight to recognize disturbing factors in a situation and to assist in a social reconstruction program that may be truly preventive. No psychiatric social worker in such circumstances considers that her work is a substitute for clinical work but rather supplementary to it. Not only adequate training and experience but also maturity and objectivity in recognizing her own limitations and assets are essentials for such work. Access to a psychi-

atrist for advice should be provided either through a supervising committee or a close relationship to a psychiatric clinic.

6. What is your feeling about the future?

All social case work now tends to approach its problems from the mental hygiene point of view. The courses now offered to those specializing in psychiatric social work are being taken more and more by those who enter into other fields of social work. The present tendency of psychiatric social workers to take up semi-independent work as organizers, as educators, as supervisors, is in part due to the phenomenal spread of the mental hygiene point of view. Later they may not be needed in such work.

As the present equipment of the psychiatric social worker is acquired by other social workers in increased numbers and degrees, many of the functions now assigned to the psychiatric social worker will undoubtedly become a part of the activities of social case workers in other fields, family case work, children's work, medical social work, and so forth. The psychiatric social worker will probably continue as a specialist in the field of social case work dealing with the more obscure behavior problems and the social aspects of the distinctly pathological cases of nervous and mental disorder. The chief concern will probably be in the experimental development of more effective methods of psychiatric social treatment for such problems and in working out more delicately the correlation of findings in the social field to the complex processes involved in the development, the understanding and the treatment of such conditions. Further specialization will probably appear in advanced theoretical courses along psychiatric and psychological lines, in increased intensity of field work experience with distinct psychiatric social problems, and in research into the sociological contributions to such conditions. Although future specialized training may develop definitely along postgraduate lines turning more and more toward scientific psychological and psychiatric content it is believed that this specialty of psychiatric social work will always remain fundamentally a part of the profession of social work and will attempt to develop and refine the contributions from that field to the total knowledge regarding human behavior.

7. *Granting that psychiatric social workers have a special training more elaborate than other medical social workers, do you see opportunities to act as teachers of other groups, or do you think that other workers should receive, in shortened form, training at psychiatric centers? The medical social worker feels that much of her work is in adjustment problems, while certain psychiatric social workers feel that adjustment should be done only by their own group.*

All of social case work is primarily concerned with some aspects of human adjustment. Psychiatric social workers merely have more specialized knowledge and more specialized experience which enables them to handle problems of emotional and behavior difficulties more adequately and intensively. Naturally most of the minor adjustment problems in the behavior field should be dealt with in the respective field of medical social work, family and children's case work along with other adjustment problems—general illness, budgets, employment living conditions, foster home placement, and so forth. However the intelligent handling of even the minor problems in the behavior field presupposes some special knowledge concerning the psychological factors and the social psychiatric principles involved. Such knowledge probably can best be obtained through training courses and experience in psychiatric centers although some general orientation can undoubtedly be obtained from psychiatric social workers acting as advisors, consultants and supervisors.

The situation facing the psychiatrist is similar to that of the psychiatric social worker regarding the range of problems to be handled. Many of the problems now referred to him undoubtedly could and should be handled by other medical men, general practitioners, pediatrists, and so forth, but this cannot be successfully achieved until at least general orientation regarding human behavior and mental hygiene is included in medical training. No one specialized group within a profession and no one profession can hope ever to deal alone and adequately with all the adjustment problems in the universe. More widespread knowledge and sound application of mental hygiene principles and more expert and precise specialization in the study and treatment of major conditions seem to be the chief needs of social psychiatric efforts.

March 28, 1931. (Signed) MILDRED SCOVILLE,
President, American Association of Psychiatric Social Workers

The point which interests the Subcommittee, and upon which there is frank difference of opinion is this. The social service worker at the beginning of her training is admittedly without a background of adequate scientific training of any sort. It seems to some of the Subcommittee that it is possible that these workers are likely to accept a single approach and will graduate without developing skepticism and an ability to select new points of view. Most of us feel that the field is not yet crystallized to a point where special training as a member of a classical team is completely justified. Miss Scoville answers some of our questions with clearness and vigor, but in the minds of some of the Subcommittee doubts still exist. All of us, however, recognize that adequately trained social workers are entirely indispensable in clinics and hospitals.

Visiting Teachers

This Subcommittee has not attempted to formulate opinions in regard to teaching methods. It is willing to admit, without qualification, that some of the best work in "mental hygiene" is done by teachers and that visiting teachers do some of the best "social service." We felt, however, that any attempt to appraise the contributions of this group would take us far afield.

LETTERS DESCRIBING TYPICAL PROGRAMS

1. Institute for Juvenile Research

Chicago, April 4, 1930

Dear Dr. Crothers:

I regret that an answer to your letter of March 8 has been so long delayed, but because of the importance which I attached to the questions raised I have taken time to go thoroughly into the matter before a reply. This caused some delay for reviewing our work as a staff.

Our clinic is open to all children who are residents of the State of Illinois. Our experience is that in the city of Chicago a relatively small number of children from families with means come for examination, whereas in the clinics in the cities of the state outside Chicago a larger proportion of such families avail themselves of the clinic service. This is largely determined in these communities by the active participation in the local clinic activities by the family with means. The Institute accepts no fee from these families.

We are sending you under separate cover some literature which we hope will be helpful to you in understanding the character of the work of the Institute for Juvenile Research.

It is very difficult for us to arrive at per capita costs in our work. If you will refer to the several reports and pamphlets which we are sending you, you will notice first of all that the number of cases seen in our institutions is considerably greater per staff employed than in the Institute itself. Furthermore, many of the clinics which are under our direction represent cooperative effort; that is to say, funds other than our own are employed in carrying out the continuity in the cases which we see.

There is a further difficulty in arriving at costs. Our objective is a threefold one. Not only do we give service, but the nature of our examination is material leading to research, and we have the further function of teaching and training, not only the students and fellows who come to us, but the development of the com-

munity point of view itself. For these reasons it will be quite impossible for us to set up a per capita cost on the basis of cases which we see.

The question as to the clinic budget being only a part of the total cost can best be answered by pointing to the influence which the clinic study has on the future treatment of that particular case as well as similar cases which may not be referred for examination. As a result of this examination by the behavior clinic and the treatment recommended, there can be averted useless, and sometimes large, expenditures of social agency funds. This is an intangible saving that obviously runs into very large figures, but which it is difficult to estimate. The amount is probably more than sufficient to cover the cost of the maintenance of the behavior clinic. Examples of this are shown by the following:

1. In a broken family supported in part by a social agency, a boy of seventeen, out of work, failed to contribute to the family support, was actually receiving part of the support from the agency. He was charged with an offense punishable by reformatory sentence. By following the advice of the behavior clinic, a program was devised by which the boy was given employment, and has now been for five months steadily employed. Thus a considerable addition to the family income has been effected. At the same time, this saved the cost of a trial and institutionalization had he been found guilty of the offense.

2. The considerable sums of money which have been provided for scholarships formerly were determined almost entirely on the school adjustment of the individual. In the course of the examination of these children in the behavior clinic evidences of personality difficulties which otherwise would have escaped notice have influenced the selection for scholarships and the kind of scholarships.

3. The child-placing society accepts dependent children for placement in foster homes, financed in part by the County funds obtained through taxation, and in part through the private agency funds. After two or three years' attempt to maintain these dependent children in the community they are referred for examination when the reduction in funds makes it necessary to make a new plan. This examination shows that these children are mentally so retarded that they can never make a place for themselves in the community. Their admission to an institution for the feeble-

minded reduces the total cost of the care of the children and plans a future for them which is in keeping with their abilities.

4. In like manner, a child of nearly adequate intelligence who was placed in twenty-three different foster homes by the very enthusiastic child-placing agency, reveals through examination that it was in the border-line group because of organic brain disease, and would probably never be able to maintain his place in the community. The disposition of this child in the state institution serves again to reduce the expenditures.

It is our opinion that adequate mental hygiene supervision at attainable cost can be given, and preferably should be given, by all of the various means which you list. The organized clinic will then serve not only to render service in specific cases, but will serve as a demonstration, influencing thereby attitudes in a community and determining technique of treatment by the agency workers.

In so far as practitioners of medicine are equipped to treat behavior difficulties, we believe that this should be done. The first step, we believe, is in the formulation for the use of practitioners of those techniques which have been developed in the behavior clinic. The second step lies in the direction of preparing the practitioner for treatment of this type of individual through specially organized class instruction in the medical school.

The extension of the knowledge of psychiatry and the psychiatric point of view is encouraged by us for individuals such as the psychiatric social worker, when this individual works as an integral part of the clinic. We do not believe that she should work independently.

We also recommend the training of teachers, such as visiting teacher, social worker, public school teacher and visiting nurse, to a larger understanding of the principles underlying psychiatry. Here again, these persons should work in connection with, and under the direction in special cases of, the psychiatrist.

There will be no objection to the use of the name of the Institute in connection with the above information. If there are any further questions which may arise I shall be very glad to try to help answer them.

(Signed) PAUL L. SCHROEDER,
Director.

2. Institute for Child Guidance

New York City, March 11, 1930

Dear Dr. Crothers:

Under separate cover I am sending you a copy of the only published report of the Institute together with a copy of the pamphlet entitled The Child Guidance Clinic and the Community. In the latter I have an article which expresses my own philosophy and viewpoints with reference to community organization for mental hygiene work. I think you will find there an expression which may substantially be stated as follows:

Leadership in mental hygiene work must come from the trained mental hygiene workers, namely, the unit of psychiatrist, psychologist and psychiatric social worker. Beyond that there are several professional groups standing in relationship to the daily lives of large numbers of children, who need to have an opportunity to develop the mental hygiene approach to their dealings with these children. These are the doctors, nurses, educators, and social workers of various types in particular. Beyond that there are, of course, those people so important in their children's lives, namely parents, who need an opportunity to learn some of the sounder and more fundamental principles of mental hygiene to use in their daily dealings with their children.

All of the professional groups have contributions to make to mental hygiene approach, which I think may be most simply characterized as an approach which takes into consideration the individual as a total personality plus the series of situations or environments in which he must live and have his being, and the mutual interaction of these which determine not only personal make-up but social behavior, and so forth. It seems to me imperative that we remember that no clinical group could, under present circumstances, possibly be large enough to deal with all the problems that might come to it. In all probability the entire group of medical practitioners is not large enough for this purpose. In addition, the medical practitioners are not particularly interested in the individual as a whole. I think this is more or less rightly so inasmuch as the general nature of their services belongs to a somewhat different category. Increasingly, however, the pediatrician is alert to these problems and his needs in relationship to

them, and there should be a much greater emphasis on problems of the total personality and problems of the psychological interplay between child and parent in the training of the pediatrician. Actually, as Grace Marcus has so well pointed out in her book, a great deal of the work of adjusting personality to personality must be carried on by people other than a psychiatrist; usually the social worker but sometimes the teacher, who is most closely in touch with these personalities at work and at play. Therefore, anything which is done in terms of increasing the technique of social workers in individual case work is all to the good. I would not regard it as diluting psychiatry, and I do not encourage independent work in this difficult field too far, but the fact remains that frequently these problems must be met on the ground and no so-called expert clinical service is immediately available.

The Report of the Institute will give a general description of the work of the Institute, and you will see that any figures on per capita cost would be on a totally false basis, inasmuch as we definitely limit our case load and pay the most attention to the training of workers in the three different fields which we regard as essential to the mental hygiene clinic. Figures on expenditures are given, but it would certainly not be fair to charge all of the budget to case work or all of it to training. If one allocated say $20,000.00 a year to research and half of the remainder of the budget to case work and half to training, you will arrive at figures which in and of themselves seem high, but are actually well within the limits both of the case work and training expenditures in certain private hospitals, certain child guidance clinics and certain medical schools.

It seems to me that we need both to expand clinics and emphasize the opportunities open to medical men and to others if they will take seriously these multiple problems and not just pass them off contemptuously as being so many words. One thing is certainly necessary, and that is to approach the field with a realization that it requires quite as much time to make an adequate mental hygiene worker, clinical director, or what not, as it does to become a specialist in any other medical field. Certainly three years is not too short a time to set as the desirable period. Tinkering with human minds is far more serious, more difficult and more conscience weighing than tinkering with human appendices or gall bladders. So long as the profession maintains its general attitude

that only those who are queer or failures are interested in psychiatry and mental hygiene, we shall not get very far in any attempt at more constructive work. So long, further, as psychiatrists tend to confine themselves to brilliant verbal pyrotechnics rather than studying and weighing the observable phenomena in all possible ways, so long will psychiatry fail in influencing the profession in the direction of a more dynamic viewpoint.

If there are further questions that occur to you with reference either to the published material or to the statements which I have here made, I shall be very glad to answer them.

Very sincerely yours,
(Signed) LAWSON G. LOWREY, M.D.

3. University of Colorado,
Denver, Colorado, March 18, 1930

Dear Dr. Crothers:

I have your letter of March 11th and beg to state that I would be very pleased to have you use any material that you have found that you see fit. The approximate expense involved in our community clinics varies in each clinic. The cost of the Durango Clinic is approximately $6.00 per examination. The cost of the Greeley and Sterling clinics amounts to approximately $2.50 per examination. This cost of course is misleading in that the actual salary of the personnel involved is not included—only the actual traveling and maintenance expenses of the psychiatrist and the social service worker. In addition, the social service worker's expenses during the full time she spends in the community are taken care of. I am glad to know that you are interested in our program which now gives evidence of coming through the preschool period with many possibilities. Please let me hear from you off and on regarding the work of your committee.

With kind regards, I am
(Signed) FRANKLIN G. EBAUGH, M.D.,
Director, Psychopathic Hospital.

4. The Mobile Clinic of the State Psychopathic Hospital, Denver.

Dear Dr. Crothers:

Since 1925, a mobile clinic from the Colorado Psychopathic Hospital has visited 101 communities throughout the state and examined approximately 1,600 cases. Most of these communities have been visited in conjunction with the Traveling Health Clinics organized under the State University Extension Bureau and the Colorado Child Welfare Bureau.

The work of the clinics was largely in the fields of education and preventive medicine. As stated in a previous paper, "A state psychopathic hospital is a community organization that should attempt to be of service to all the localities of the state in furthering early recognition and treatment of mental disorders and defects. A mobile clinic can aid in this program very materially in the following ways: (1) It can establish actual contacts with the community which makes it easier to evaluate the social forces surrounding the individuals who come to the hospital for treatment. (2) It can collect data as to schools, arrangements for recreations, type of vocations and numerous other important factors that contribute to the social welfare and adjustment of patients. (3) It can secure at close range important information as to environmental influences to serve as a basis for the hospital recommendations prior to the patient's discharge. (4) It can bring before each community in a thorough and intimate fashion the aims and purposes of the hospital, matters pertaining to the admission and discharge of patients and information as to current trends in preventive psychiatry. (5) It can form actual contacts with local physicians. (6) It makes possible the neuropsychiatric examination of adults and of children of preschool age and school age who present behavior and habit training difficulties. (7) It can aid in the establishment in the school of special classes for retarded children whereby their capabilities will be better developed and their social and economic status improved."

The work of the clinic as a whole consists of a complete health examination of the preschool children and such school children and adults as may be referred by the local community. This includes an examination of the teeth, the eyes, the ears, nose and throat, weighing and measuring to determine the relative state of

nutrition and a complete examination to determine if any other physical defects exist. A summary of the developmental history is made and on the basis of this summary, recommendations in regard to prophylactic measures such as vaccination, toxin-antitoxin, and so forth, are given. From this group the pediatrician and other clinic workers refer cases to the psychiatrist as the indication arises. In addition to cases referred through the regular clinic channels, cases are also referred by the local physicians, school principals and teachers and court officials for psychiatric examination only.

The scheme of classification used in examining the children referred is the same as that used in the Psychopathic Hospital. The classification groups them under five heads: namely, the reactive behavior or personality defect group, the toxic and organic group, the mental deficiency group, the endocrine group, and the psychotic group.

The reactive behavior group includes those children who are showing a maladjustment on the basis of inadequate or poorly developed personality assets, bad environmental surroundings, or both. Emotionally unstable, overactive and underactive types are placed in this group. Friction between members of the immediate family, poor hygienic arrangements, inadequate parental control and faulty understanding of the parental control and faulty understanding of fundamental facts of child psychology by the parent are important causal factors. Maladjustment may be evidenced by temper tantrums, failure in school, delinquency of various kinds, numerous habit spasms and tics, asocial or anti-social conduct and many other types of undesirable behavior.

In the organic group are placed those children who are presenting problems on the basis of definite organic disease, such as congenital syphilis, post-encephalitic behavior disorders and various post-traumatic conditions, birth injuries, and so forth.

The mental deficiency group includes those children in whom there is a definite primary reduction of mental capacity and ability, not attributable to any of the organic factors mentioned above.

The varied types of glandular dyscrasia—thyroid, pituitary, and so forth, with their marked influence on the mental status, comprise a small but definite group.

The psychotic group includes adolescents who may present many features of actual psychoses such as manic-depressive states,

schizophrenic reactions, parenoid reactions and constitutional psychopathic inferiority.

During the three years in which the clinics have been active, 12,500 children and adults have been examined. For purposes of comparison these have been divided into two groups of an equal number. This division approximates an equal division in the time factor and in the number of communities visited as well.

Of the first 6,250 cases passing through the clinic 667, or 10.5 per cent, were referred to a psychiatrist. Of the second 6,250 cases, 835, or 13.4 per cent, were referred for psychiatric examination, a gratifying increase. Of the first group, 242, or 36 per cent, were classified in the reactive behavior disorder group. Of the second group, 497, or 59.5 per cent, were placed in that classification. This also was encouraging since these children in the main represent normal children with remedial personality difficulties providing the remedial measures are begun early. Included in the second group are 93 adults who were examined.

One hundred and ninety-eight, or 30 per cent, of the first group were classified as organic reaction types and only 117, or 14 per cent, of the second group. This unusually high incidence, especially in the first group, is attributed to two main factors; first, the large number of birth injuries encountered due undoubtedly to the absence of an obstetrician or at best the attendance of a midwife; and second, the large number of cases of untreated syphilis. The character of the population in the communities visited as well as the lack of medical facilities in some vicinities made these conditions possible.

Of the mental defective group, 78, or 10 per cent, were encountered in the first group and 87, or 10.4 per cent, in the second. Of the endocrine group, 12, or 1.8 per cent, were found in the first group, and 4, or .4 per cent, in the second. Eleven children, or one per cent of the first group, showed definite psychotic tendencies, and 37, or 4.4 per cent, of the second group.

The problems presented by the defective children were largely in association with their school work. In one community visited it was found that the fourth and fifth grades were about one-fourth larger than the other grades in school. Psychometric examination disclosed the condition that this increase was due to the fact that there was a large number of pupils who were reaching the limit of their scholastic achievement at these grades and were

not being promoted because they were unable to complete their work. Faced constantly with problems that were beyond their comprehension they resorted to misconduct and mischievousness to occupy their time. By making arrangements whereby occupational and mechanical training was provided for these children, the school situation was relieved and the status of the children was considerably improved.

The relatively high incidence of the number classified as psychotic in the second group was due to the fact that a number of patients who had previously been in the hospital were examined during the clinic visit to their community.

Visits to the same communities in successive years has convinced us of the necessity for the establishment of permanent base clinics located at points throughout the state where they could serve as centers for the surrounding territory. Problems in a great many instances are problems of social adjustment and as such are best met by an organization that is in touch with local conditions throughout the year. It has been gratifying to see the results of successive visits to a community, but adequate follow-up can only be effected through a permanent local organization. Such an organization has been developed at Sterling and is functioning very well.

A résumé of the work of a mobile clinic shows a marked increase in the scope of the work undertaken through that agency. It has aided materially in the educational program of the state Psychopathic Hospital and has led to a better understanding of the social forces at work throughout the state and the influence these may have on the production of mental disorders. It has been an excellent agent to carry out the initial program in the work of preventive psychiatry. It has indicated the need of permanent local organizations and contacts made thus far in each community should lead to the development of psychiatric clinic centers.

FRANKLIN G. EBAUGH, M.D.,
G. S. JOHNSON, M.D.,
Department of Psychiatry,
University of Colorado School of Medicine, Denver.


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Philippine Islands


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